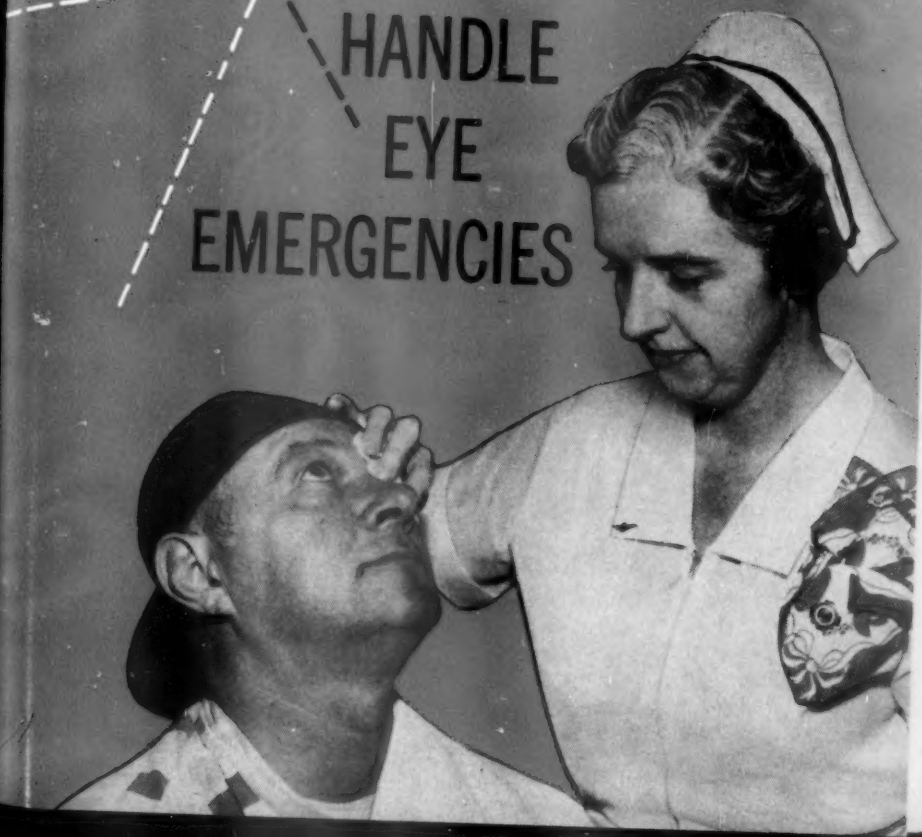
RN

FEBRUARY 1959

HOW WE HANDLE EYE EMERGENCIES



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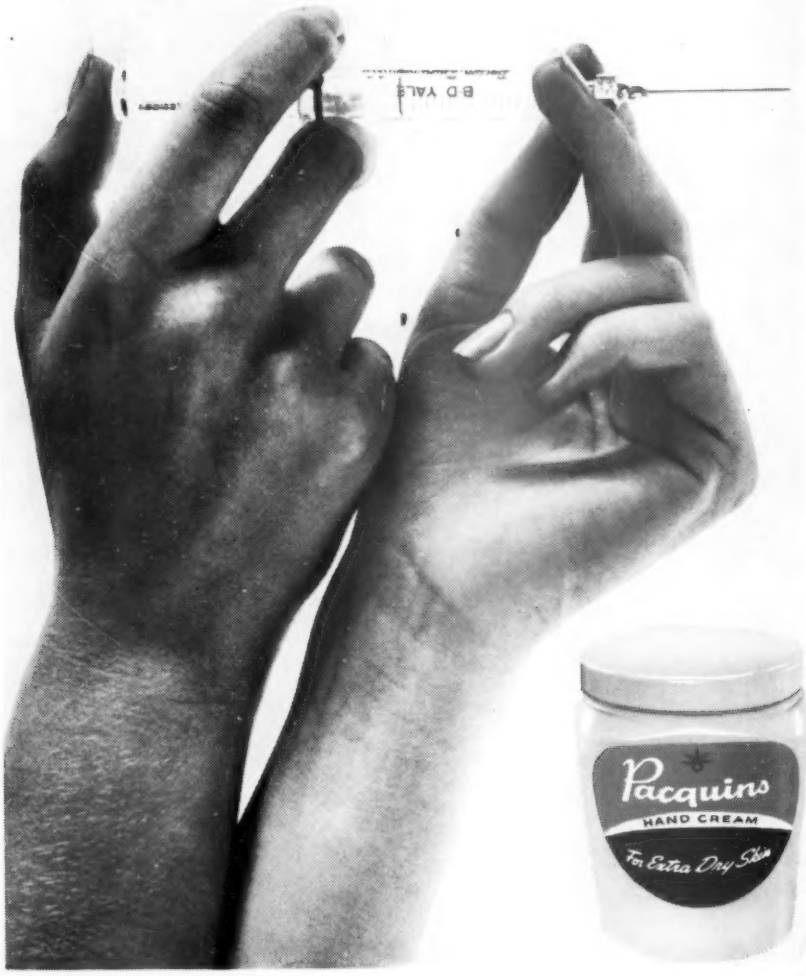

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MORE ►

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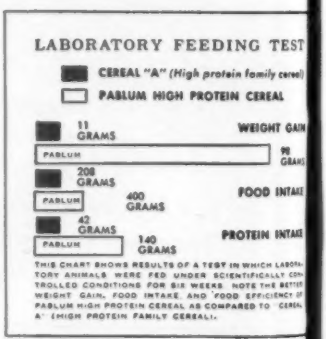

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Why chewing-gum antacid is so effective against Heartburn of Pregnancy

by Kitty McKay Leith, R.N.

Whenever new mothers and mothers-to-be get together, the conversation sooner or later gets around to heartburn, for it is one of the most common and persistent causes of discomfort during pregnancy.

Since the day, centuries ago, when the Swiss physician Paracelsus von Hochenheim prescribed powdered pearls to relieve this complaint, many remedies have been developed—powders, liquids, tablets and, probably most unusual of all, even an antacid in convenient, good-tasting chewing gum.

Recently, to compare the merits of leading antacids now available, a group of doctors and scientists conducted an extensive series of experiments. Since it is impossible to test an antacid in the stomach with any degree of dependable accuracy, the tests were done *in vitro* (the laboratory term for "in glass") under a close simulation of actual stomach conditions.

A number of identical glass containers were filled with equal amounts of artificially made gastric juice, which was maintained at body temperature and stirred continuously. To this "juice" the antacids were added, in a way that duplicated the recommended dosage. At timed intervals, part of the mixture was removed and replaced with fresh "juice" to simulate emptying of the stomach and continued secretion of gastric juice as it occurs in nature.

Changes in the acidity of the mixture were checked throughout the tests.

The tests proved conclusively that the antacid in chewing-gum form (Chooz®) was the most effective of all. It not only neutralized excess acid fast, but also maintained it at the desired acid-alkaline balance at least 3 times longer than any of the other leading antacids included in the tests.

In explaining the impressive results obtained with Chooz, the researchers give credit to two things—1, the effective medicines it contains, and 2, the unique chewing-gum form.

Tablets, they point out, usually enter into the digestive tract in partly chewed chunks, soothing only part of the stomach. Powders and liquids enter the stomach all at once and are also often inconvenient to take just when they are most needed.

On the other hand, chewing carries the Chooz medication into the stomach continuously—in ready-to-act solution with saliva, a natural digestant. Then Chooz not only starts its acid-neutralizing action instantly in all parts of the stomach, but continues to soothe with a steady, gentle flow of medication for far longer-lasting relief.

Through special arrangement, R. readers may obtain a trial supply CHOOZ, free. Just send name a address to Kitty McKay Leith, R. P. O. Box 37, Kenilworth, N. J.

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RN letters

OFF THE PEDESTAL

DEAR EDITOR: Recent graduates seem to encourage the use of their first names when being addressed. How do your readers feel about this?

And what about reporting on duty stockingless?

These are but two of the many changes taking place in a once proud calling.

Margot D. Schaaf, R.N.
Kew Gardens, N. Y.

HOURS, PAY, AND A.N.A.

DEAR EDITOR: "If it weren't for our national and state organizations," says one of your correspondents, "we'd still be working twelve hours a day, six days a week, at smaller salaries."

Come, now, give us credit for a little common sense.

The trend of the times—not nursing organizations—has led to better pay and shorter hours for nurses (just as it has for elevator operators).

I, for one, have to be shown that these organizations help us salary-wise. Yet I'm not a "piggyback rider"—I belonged to local and state groups until dues got too high.

I hope those in my R.N.-daughter's age group will have more financial security at retirement than nurses my age will have.

Blanche Marks, R.N.
Galt, Calif.

TAXES BE BLESSED!

DEAR EDITOR: Having given twenty-seven years to general duty, I feel qualified to answer the R.N. who suggests that general duty nurses be exempt from withholding taxes.

It seems to me that we should recognize how fortunate we are to be living in the most blessed land on earth. And being so fortunate, we should be entirely willing to pay our share of necessary taxes—thanking God for the privilege.

In many another country, we'd be run to the ground by the Communists.

Sybil E. Watson, R.N.
Philadelphia, Pa.

FUDDY-DUDDIES WANTED

DEAR EDITOR: Why are hospitals today fighting staph? Because true asepsis has been cast aside by our almost fanatical reliance on antibiotics.

Recently I saw an O.R. instru-

letters

ment table left uncovered for an hour and a half. (The surgeon had been called to the delivery room just before starting a D. & C.) When I insisted on a fresh sterile set-up for the surgeon, the O.R. supervisor ungraciously reminded me that we now have penicillin. Meaning, of course, that I'm just an old fuddy-duddy.

Where are the supervisors who used to see and correct every contamination immediately? Who today teaches the budding surgeon to follow asepsis unfailingly and to demand that it be followed by his assistants?

Aren't there enough old fuddy-duddies left to reinstill in surgery the lost art of true asepsis?

Iona M. King, R.N.
Detroit, Mich.

SQUEAK UP!

DEAR EDITOR: The Taft-Hartley Act specifically exempts nonprofit hospitals from the obligation of bargaining collectively with their employes.

Why such a heinous exemption when hospitals are the country's fifth largest industry?

Organized nursing is on record as being opposed to this exemption. Isn't it time that every hospital nurse also put herself on record as opposing it?

Write to your Congressmen, Nurse! Tell the Representative from your district and the two Senators from your state how this

Taft-Hartley Act affects your economic status.

Congressmen read their mail. Your letters will not be overlooked.

It's the squeaky wheel that gets the grease. So let's squeak together where we'll be heard—in the halls of Congress where the Taft-Hartley Act was concocted. Many squeaks make a roar!

M. Elinor Reichert, R.N.
Bethesda, Md.

TIMELY HELP

DEAR EDITOR: Your article, "Emergency Technique for Rh Babies," was especially useful to me, for it explained the set-up for exchange transfusion just when I needed such information for an OB-nursery assignment.

Grace E. Thomas, R.N.
Bremerton, Wash.

REPORT ON HYPNOSIS

DEAR EDITOR: My 16-year-old daughter had an impacted wisdom tooth removed recently under hypnosis. She felt no pain, had no bleeding, needed no retractor or gag. Her postoperative recovery was almost unbelievable.

She had previously been aided by the hypnotist—a young doctor—in breaking her nail-biting habit and in overcoming tensions. And

The Care and Feeding of Baby Teeth

For those months when baby is learning to chew: Gerber Junior Foods are ideally suited to help older tots and toddlers make the transition from strained to regular family table foods. Evenly minced texture is easy to manage. Particles are soft, yet have enough bulk to encourage chewing action . . . pave the way for coarser foods. Brighter flavors appeal to awakening taste buds. Combination foods have more flavor interest . . . prepare baby for more grown-up dishes.

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letters

he had cued her for further hypnosis with surgery in mind.

When the time came, she readily accepted her cue—a touch on the left shoulder. The tooth was drilled and removed in pieces. During surgery, the hypnotist repeatedly reassured her by speaking to her and by placing his hand on her left shoulder. With each touch, she told us later, she became more and more relaxed.

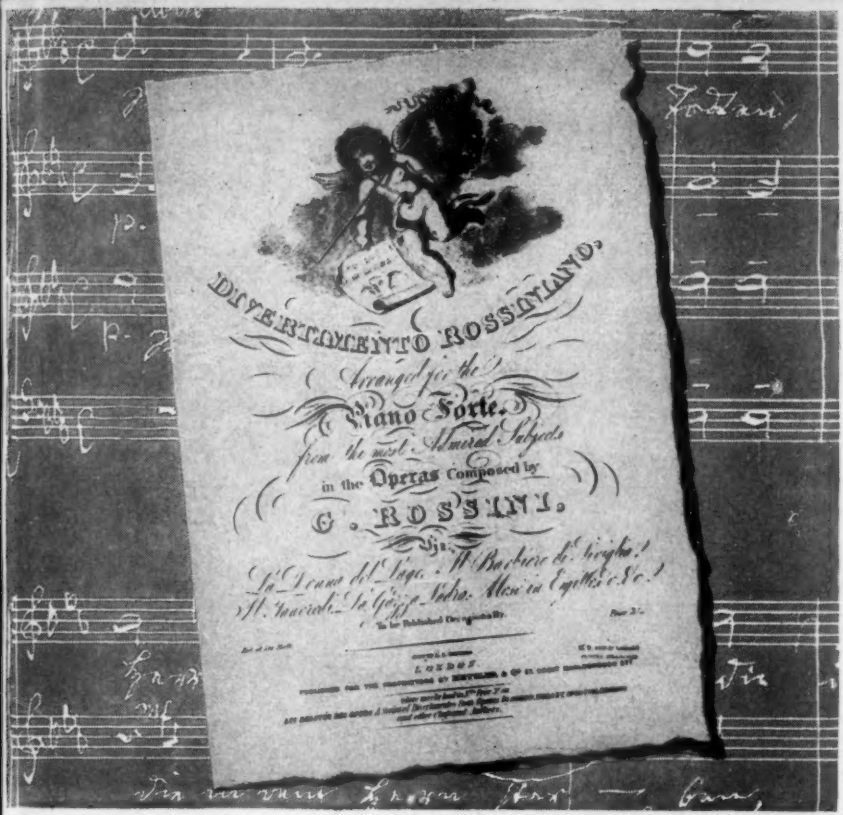
After the operation, she opened her eyes when told to and said she felt fine. Then she stepped out of the chair, walked to the car, and was driven twenty-four miles to our home.

Postoperatively, she used no ice and took aspirin (twice) the first day only. She had a little swelling but it subsided within thirty-six hours. She brushed her teeth, and ate steak the first day.

Her sutures were removed under hypnosis the seventh day. By then her recovery was complete, and she had no discomfort at all.

The previous year, when she underwent the same kind of surgery, Pentothal Sodium was used for anesthesia. After that extraction, she had to use ice packs half the time for eight hours. Empirin with codeine was also required. Her jaw was quite swollen and discolored, and she didn't feel well for ten days.

Ada Rose Donaldson, R.N.
Clinton, Ill.



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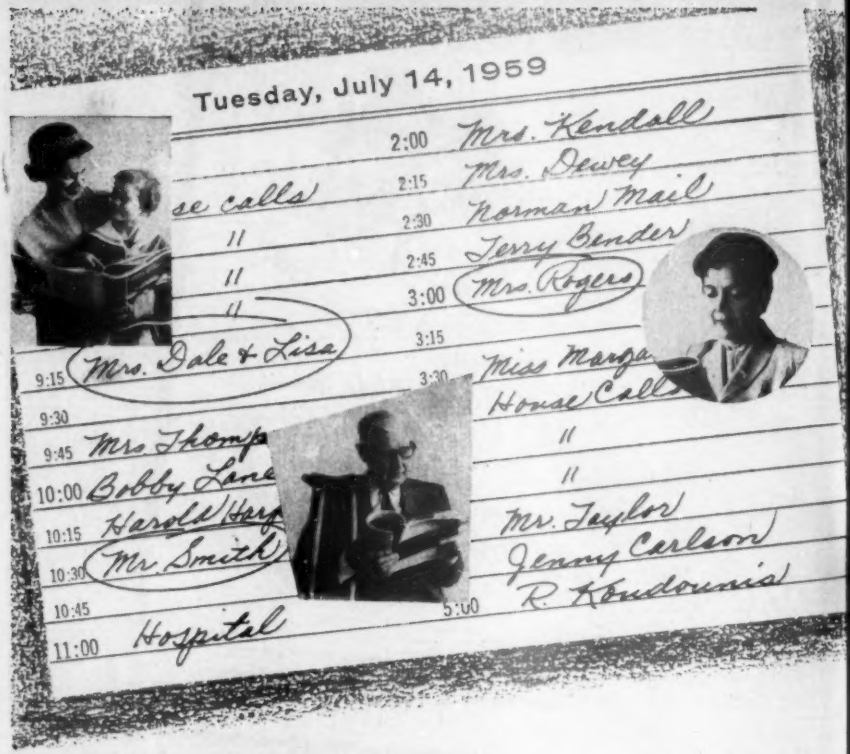

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*Riboflavin	2.0 mg.
Pyridoxine	0.5 mg.
Vitamin B_{12}	5.0 mcg.
Pantothenic acid	3.0 mg.
*Niacin	10.0 mg.
Folic acid	0.05 mg.
Choline	200 mg.
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1. Spies, T. D.: The Influence of Nutritional Processes on Aging, South. M. J., *50*:216, 1957.

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RN news

eg Ulcers Healed y Sugar Paste

eg ulcers, both stasis and decu-itus, that had been troubling eir patients for an average of one ear, were healed or improved hen physicians at the University f Illinois Medical School treated em with sugar paste.

The paste they applied to the sistant ulcers twice daily for a-out three months was made of 0 gm. powdered cane sugar, 60 m. anhydrous lanolin, and 2 ml. ompound benzoin tincture. Of ineteen patients 50 to 76 years d, nine showed complete healing; e others showed considerable im-rovement.

Dr. Adolph S. Rostenberg Jr. d his colleagues report that no astic bandages and no medica-ons other than the sugar paste ere used.

How does the paste work? They n't know yet.

ong Stays Are Too Long, ospital Study Hints

out a third of the patients who y longer than thirty days in a spital don't need to. They'd be tter off in good nursing homes—or in their own homes if cared for by visiting nurses.

That's the gist of a preliminary report covering a study of Jewish hospitals in Philadelphia, Miami, Chicago, and St. Louis. The study is being conducted by Dr. Franz Goldmann of New York.

Blames Fads and Mothers For Poor Nutrition

Food fads and overly devoted mothers, says Dr. Harold D. Lynch of Evansville, Ind., are responsible for widespread malnutrition—especially among children—in the U.S. He urged doctors attending the recent A.M.A. meeting in Minneapolis to help dispel the public's misconceptions about diet.

"Our children are carefully provided with vitamins and minerals," he says. "But protein, the master nutrient, is neglected. As a result, our children are growing fat and flabby on foods they don't need."

One reason for this, says Dr. Lynch, is the mother's desire to win her child's approval. Solid protein foods need to be chewed, and they're not sweet and tempting. But desserts, beverages, and sweet snacks readily win the child's ap-

proval. So the mother gives he child those whenever she can.

"This permissive and instinctiv diet does not contribute to goo health," warns Dr. Lynch. Routin examinations of school childre he adds, show there is as muc malnutrition in prosperous scho districts as in poor ones.

Hospitals' Sleep Rules Dated, Says R.N.

Waking patients at the crack dawn and ordering "lights out" 8:30 P.M. may have been justifi in the kerosene-lamp era. But isn't a sensible routine for a hos tal to follow today. So says An Frances Brown, R.N., a Rock Isla (Ill.) specialist in nursing researc

The early-to-bed, early-to-r rule actually prevents patie from getting adequate rest, s feels, since most of them aren't the habit of going to bed early a often lie awake for hours.

Miss Brown also feels that h pital meal hours should be plann for the convenience of patients and not for that of employes.

Deathbed Scenes Lack Dignity, He Claims

Are modern hospital techniq robbing the patient of his right die in peace and dignity? T seem to be, says Dr. John J. F rell of the University of Mia pointing out that all too often family is shoved out into the

n vaginitis

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hether vaginitis is caused by Trichomonas, Monilia or Hemophilus ginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves mptoms and malodor, and achieves a truly high percentage of cul- ral cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED ovides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, e *established* specific trichomonacide FUROXONE® brand of furazolidone d the *combined* actions of both against Hemophilus vaginalis.

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ROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides.

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ridor by the presence of intravenous stands, suction machines, oxygen tanks, and tubes emanating from every natural orifice—and from several surgically induced ones."

The scene that results, he says, is a far cry from the Biblical picture of "a patriarch surrounded by his children and his children's children, sorrowing but eager to hear the last wise words of counsel from the lips of the dying man."

Today, by contrast, says Dr. Farrell, the last words of the patient are lost behind an oxygen mask or some other anesthetic piece of equipment.

Urine Specimens Used For Gastric Analysis

Tubeless gastric analysis is now being performed at the Rochester (N.Y.) General Hospital. Physicians there determine gastric acidity by administering granules of a dye called Azure A, then collecting all urine voided in the next two hours. When free hydrochloric acid is present in the stomach, the blue dye is absorbed and excreted in the urine.

Dr. Harold L. Rosenthal recently reported the results of a one-year study of the method to the American Medical Association. He finds tubeless gastric analysis useful in diagnosing pernicious anemia, gastric cancer, and duodenal ulcer. The technique makes it possible, he says, "to ascertain the state of gastric acidity in specific cases or in mass screening examinations without the use of complicated or cumbersome chemical procedures."

Anniversaries Found To Upset Emotions

Not infrequently, illness of emotional origin will strike a person on an important anniversary. This has been found most likely to occur on the anniversary of the death of a parent toward whom the patient harbored a subconscious hostility.

Such "anniversary reaction" is described by Dr. Edward Weiss in GP magazine. The patient, he says, isn't aware that his tension is connected with the anniversary. When the connection is explained to him, he generally improves.

Certain birthdays often depress people, Dr. Weiss adds. Women are most likely to be depressed on their forty-fifth or fiftieth birthdays, men on their sixtieth or sixty-fifth, he finds.

Incubator Device Keeps Preemies at 98.6 F.

Incubators with a heat-control system, developed at Babies Hospital in New York, reportedly keep temperatures of premature infants —whose heat-regulating mecha-

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Massengill Powder has a "clean" refreshing fragrance. It is favored all over the country.

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Massengill Powder has a low surface tension which enables it to penetrate into and cleanse the folds of the vaginal mucosa.

Indications: Massengill Powder solutions are a valuable adjunct in the management of monilia, trichomonas, staphylococcus, and streptococcus infections of the vaginal tract.

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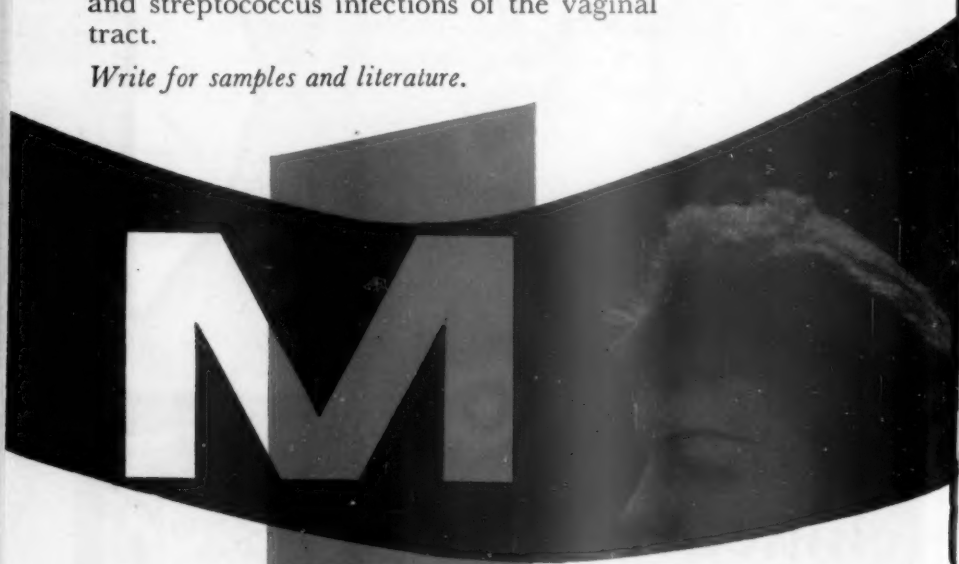

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Souderton, Pa.	*"I like Massengill Powder much better than vinegar."*
Waukegan, Ill.	*"I find Massengill Powder more pleasant to use than vinegar."*
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Youngstown, Ohio	*"I have recommended Massengill Powder ever since I tried it."*
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Union Grove, Wis.	*"It is refreshing to use Massengill Powder and also to know you are using a properly compounded material."*
San Manuel, Ariz.	*"I used to have a great deal of trouble with vaginitis, have completely stopped it since using Massengill Powder."*
South St. Paul, Minn.	*"I like this powder best of any douche preparation I have used."*
Los Angeles, Calif.	*"I have found it excellent, having recently had a hysterectomy, with of course, vaginal drainage."*
Newhall, Calif.	*"Recommended it to a case of stubborn virus infection with excellent results."*

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Bristol, Tennessee

news

nisms are poorly developed—at a constant 98.6 F.

Radiant heat lamps that respond to temperature controls are attached to the baby's abdomen. There's also a heat-sensitive element enclosed in glass that sets off an alarm if the temperature in the incubator rises above the danger level.

More Nurses Relieved Of Dietary Chores

Back in 1952, nurses were serving patients' meals in 48 per cent of the country's hospitals. Today, this practice is followed in less than 22 per cent.

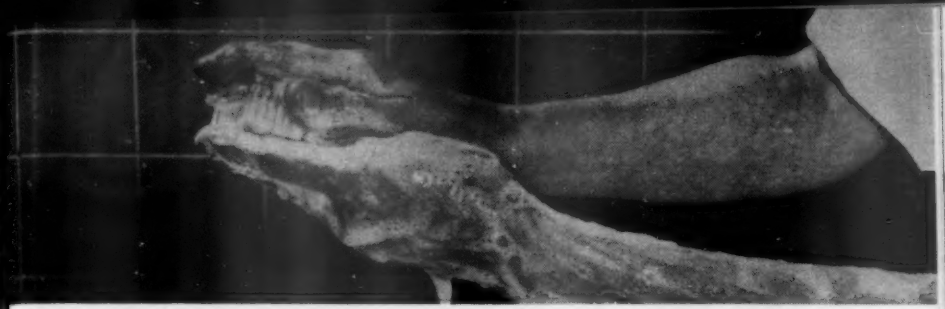
The same trend applies to the handling of special diets: Portioning, done by nurses in 20 per cent of the hospitals in '52, is now done in only 13 per cent; and serving, then practiced in 33 per cent, is now done in less than 19 per cent of the hospitals.

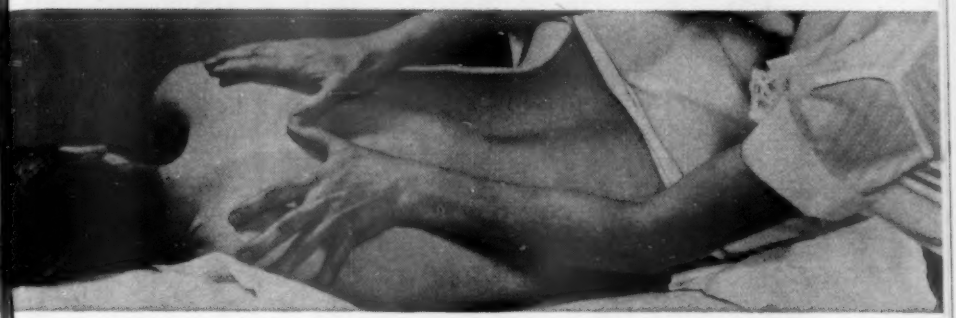
These facts emerge from surveys conducted by the Paper Cup and Container Institute. The results, says the institute, are based on responses from a cross-section of the country's directors of nursing; and their replies indicate that hospitals are seeking to make better use of nurses' time.

Among other things, the institute reports that:

¶ Paper containers are being used increasingly for dentures, lab specimens, and barium meals.

¶ Paper wipes, towels, and other





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—LeVan, P., Sternberg, T.H. & Newcomer, V.D.: Cal. Med. 81:210, 1954.

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labor-savers are likewise being pressed into service wherever there's an opportunity to save professional nursing time.

¶ About 90 per cent of the reporting hospitals now use paper medicine cups for dry and liquid medications and other nursing uses (as compared with 74 per cent in 1952).

¶ The reasons given for switching to paper for medication are that paper saves time and breakage, lessens the danger of infection, is convenient and economical, and is less dangerous for mental patients, children, etc.

Isolate the Newborn, Pathologist Urges

Nursery contagion could be averted if each newborn were isolated with its mother, suggests Dr. Edith Potter of Chicago's Lying-in Hospital.

When this couldn't be done, she would minimize the danger of contagion by replacing the central nursery with small units. No unit would have more than four cribs —and their occupants would all be new arrivals, born within twenty-four hours.

In each of these small units, Dr. Potter would have a separate round-the-clock nursing staff, with no interchanges of personnel permitted on any shift. Each unit would also have its own daily delivery of autoclaved linen and other necessities, with no interchanging of these items either. Rigid asepsis would be the rule throughout.

Nursery epidemics, she adds, are never the result of an infant disease going haywire. They represent simply a failure in asepsis.

Doctors Transfuse Blood Directly Into Aorta

A series of five patients who recently went into shock during abdominal surgery and failed to respond to intravenous or intra-arterial blood transfusion, had blood transfused directly into their aortas by surgeons at Walter Reed Army Hospital, Washington, D.C. In from five to twenty minutes, the doctors say, the blood pressure of the patients so treated was stabilized. And no damage to any aorta or surrounding tissue was observed.

Col. H. L. Riva describes the technique in a recent issue of "Obstetrics and Gynecology":

The intestines are displaced on the abdominal wall and the aorta exposed by making a vertical incision in the posterior peritoneum. Then an angulated needle, attached to a sterile transfusion set and a 500 ml. bottle of blood, is handed to the surgeon. After he inserts the needle into the abdominal aorta just above the [*More on 96*]

erything seems normal, but that "I just fall apart in the afternoon" may indicate a common subclinical anemia, or even an early pernicious anemia. For any phase or any type, marginal to manifest, consider one of the new Lederle hematinic formulations, FALVIN, PRONEMIA or PERIHEMIN. All provide the new form of iron, ferrous fumarate (fewer g.i. reactions and fully efficient) plus AUTRINIC Intrinsic Factor Concentrate, producing higher B_{12} serum levels.

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ORAL DIABETES THERAPY: Nurses who would like to learn about Diabinese, the recently announced oral agent for hypoglycemic therapy, may have a copy of a professional information brochure. Included are chemistry, pharmacology, indications, a report of clinical studies, and other pertinent data. PFIZER LABORATORIES. **B-2**

HOME MEDICINES: Fifty years ago home medication was a primitive and quaint phase of American life. Today these products support a huge industry. "Your Home Medicine Chest," by Dr. Frederick J. Cullen, is a brief history of packaged medicines and the safeguards that control their manufacture and use. It is a publication of The Proprietary Association. Well illustrated and truly informative. **B-3**

INDUSTRIAL DERMATITIS: More than 60 per cent of all occupational disease comes from industrial dermatitis according to an estimate in a booklet describing the industrial preparations of John H. Breck, Inc. Characteristics and purposes of various products are described. **B-4**

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[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958. Nonbuffered Material Used—Bayer® Aspirin.

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References: 1. Pratt, J. H. and Jackman, R. J., Proc. Staff Meeting, Mayo Clinic 20:277, 1945. 2. "Injuries to bowel as result of an enema", Frech, H. C. and Lanier, L. R., Jr., Am. J. Obst. & Gyn. 74:146, 1957. 3. Bookmiller, R. N. and Bowen, G. L., "Textbook of Obst. and Obst. Nursing", 3rd Ed., Saunders, 1958.

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SEBACEOUS ACTIVITY AS RELATED TO HEALT

Dermatologic Research for Improved Cosmetology Today, scientific principles a essential in formulating cosmetic products. Many new synthetic compounds and procedu have been developed. But controlled research has not kept pace with these advances. "T need for increasing the scope and number of investigations relating to fundamental proble of skin physiology, biochemistry, pharmacology, and toxicology cannot be stressed t strongly."[1]

Much remains to be learned of the relationship between sebaceous gland activity and t cosmetic care of the skin. Confusion exists among physicians, pharmacologists and cosme chemists concerning the use and properties of a skin emollient[2]—which may be defined "...externally applied material that tends to prevent or counteract the symptoms and sig of dryness of the skin."[2] The emollient preparations of the cosmetologist and the topic prescriptions of the physician have much in common.[2]

The Sebaceous Glands... Key Factors Sebum, the excretory product of the sebaceo glands, forms a film which diffuses all over the skin's surface and penetrates between t horny lamellae of the stratum disjunctum.[5] This film protects against abrupt temperature a humidity changes,[3] and helps to maintain the normal resiliency and hydration of the hor layer.[4]

Distribution of the Sebaceous Glands Sebaceous glands cover the body surface w the exception of the palm and the sole and dorsum of the foot.[5] They are found in great abundance—approximately 400 to 900 per sq. cm.—on the scalp, forehead, face and ch over the rest of the body—in quantities that average less than 100 per sq. cm.[5]

Structure and Cellular Morphology The sebaceous glands are acinar, holocrine glan Mitosis originates from the outermost germinative cells of the gland and proceeds thro successive layers in a continuous stream of oil-forming cells toward the center. During t movement, cells grow larger with an accumulation of fat droplets. Finally, fat distens within cells becomes so great that cell walls disintegrate with the liberation of lipid.[4]

Histochemical studies[7,8] show phospholipids in the matrix cells of the acini and their grad disappearance with increased lipid infiltration. This transformation has been linked w mitochrondrial filaments and Golgi elements.[5,9] Immature cells contain glycogen.[10] Succi dehydrogenase,[11] alkaline phosphatase,[12] and nonspecific esterases[13] have been noted.

Mechanism of Sebum Excretion and Distribution Three factors chiefly regul sebum flow to the skin surface—(1) number of glands in a unit area; (2) skin temperatu and (3) emulsifying action of sweat.[4] Starting with a defatted surface, excretion sets in rapi When the surface layer reaches a thickness sufficient to counteract the glandular force, expulsion stops.[14,15] With subsequent defattings, excretion is resumed.[14,15] A recent repo disputes this "feedback" concept claiming that "...the sebaceous gland functions conti ously, without regard to what is on the surface."[16] High temperatures keep the film liqu at low temperatures, sebum solidifies and counteracts glandular excretion at lower leve Sweat secretion emulsifies sebum and facilitates its spread.[18] The tremendous effect of swe ing on spreading of the film has been shown.[18] Regional differences in sebum secretion paralleled by corresponding changes in sweat delivery.[19]

Chemical Composition of the Skin Surface Film The surface film is a comp mixture of fatty acids and their cholesterol esters, wax alcohols, glycerol, free choleste and hydrocarbons—notably squalene.[20] Free fatty acids apparently contribute to the a pathogenic[21] and "self-sterilizing"[22] character of the film. The wax alcohols and choleste

D CARE OF NORMAL AND AGING SKIN

as emulsifiers. Squalene is typical of human fat while its chemical counterpart, lanosterol, peculiar to the sheep. Horse sebum bears the closest known relationship to human sebum[6] spite commercial claims made for lanolin in this respect.

luence of Sex Hormones on Sebaceous Activity Sebum secretion rises sharply h puberty.[23] It then levels off, becoming constant at about 25.[24] In old age there is a crease of sebaceous activity in women.[25,26] Sex hormone factors are critical for the mulation and development of sebaceous gland activity. "Progesterone definitely stimulates aceous gland growth,"[6] by increasing the number of sebaceous cells.[4] A pituitary factor, otropin, appears to be essential for the maintenance of the sebaceous glands and for their king response to stimulation by the sex hormones.[27]

pical Management of the Skin as Related to Its Sebaceous Activity The new ntific soaps and detergents have proved useful for needed day-to-day removal of excess as seen in seborrheic and greasy skins. Dryness responds to suitable emollients which act the skin surface to help guard against undue moisture loss. "An effective emollient must so constituted that it will help the stratum corneum maintain an adequate water content."[2] aging skin the problem is to help the skin by stimulating lost sebaceous function. Pro- terone applied topically increases the surface emolliency of dry, aging female skins as wn by *in vivo* staining of unsaturated fats at inunction sites and in tissue sections.[28]

uty Through Science At the Helena Rubinstein Laboratories, the application of blished dermatologic principles to scientific cosmetology has resulted in preparations provide benefits far beyond mere adornment. Of special importance to the maturing an has been the development of Helena Rubinstein's Ultra Feminine Face Cream . . . culmination of 30 years' intensive dermatologic, endocrinologic and cosmetologic research the topical effect of combined estrogens and progesterone on aging skin. Clinical s[29] indicate that such therapy can help the patient maintain her youthful skin tone well "middle age."

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Skin Grafting for Burns

Part two of an up-to-the-minute report on current methods of treating third-degree burns

By Curtis P. Artz, M.D.

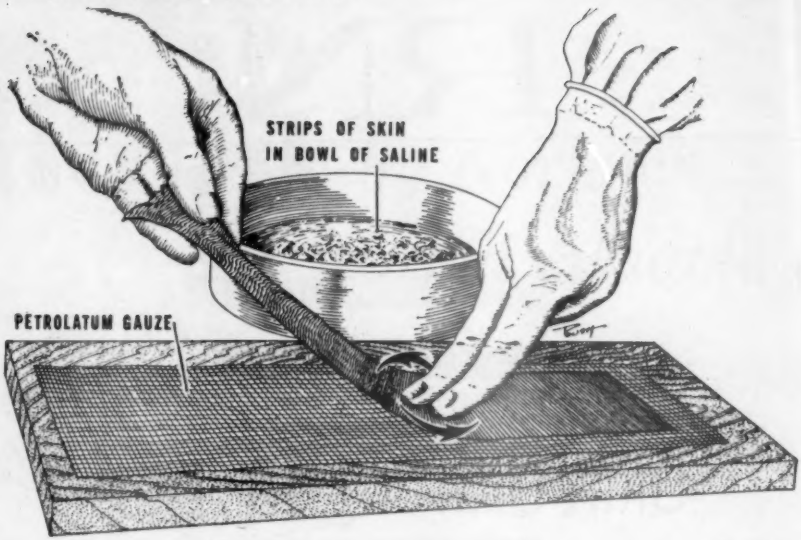
Burn wounds are covered as soon as possible with permanent skin grafts. These grafts must be *autografts*; that is, they must be taken from the victim's own body.

Split-thickness grafts are the most practical. They are obtained by shearing off just the top half of the skin layer. This leaves enough tissue behind so that the donor sites heal quickly and can be used again if necessary.

Grafting—a major surgical procedure—is almost always done in the O.R. under general anesthesia. If the patient is in good condition and has enough healthy skin to provide cover for all his burns, a team of three or four surgeons and several nurses can do the whole job at one time. Sometimes, however, the uncovered areas must be dressed

DR. ARTZ *is a former director of the Brooke Army Hospital's burn center at Fort Sam Houston, Texas. He is also co-author, with Dr. Eric Reiss, of "The Treatment of Burns," published in 1957 by the W. B. Saunders Co., Philadelphia.*

SKIN GRAFTING FOR BURNS



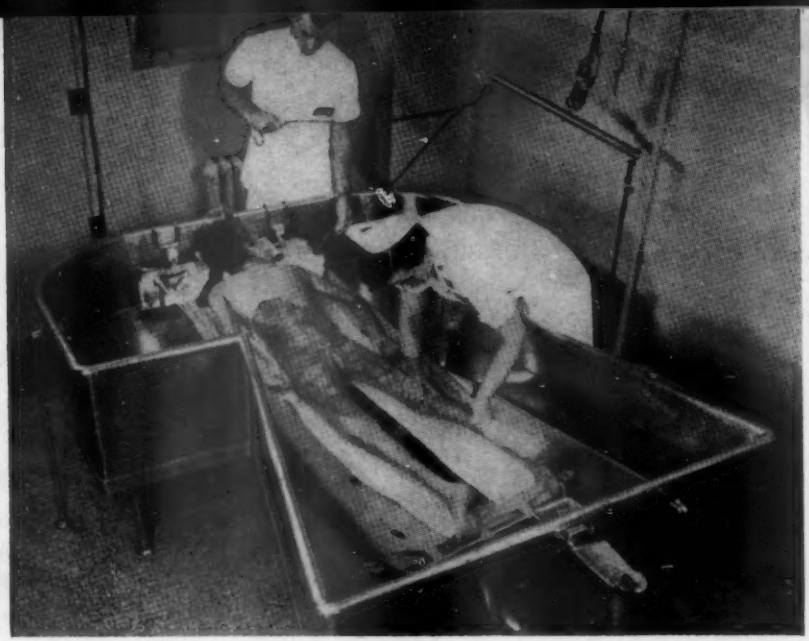
PREPARATION OF SKIN GRAFTS: *Strips of skin removed by the surgeon from donor sites are dropped into a basin of warm saline solution. The scrub nurse selects a strip, spreads it out smoothly (raw side up) on petrolatum gauze, then trims and folds it ready for use.*

with homographs or placental membranes until the donor sites have healed and the patient is strong enough to undergo autografting again.

In the course of grafting, the skin is usually removed from the donor site with a dermatome. This cutting instrument is pushed slowly over the skin, shearing off a strip one to three inches wide and about .015 inches thick.

Most surgeons use the Brown electric dermatome; with this instrument, the necessary skin preparation includes a thin coating of mineral oil. If a graft is being taken from an uneven surface (over the rib cage for example), the area may also be infiltrated with normal saline solution to provide a firm flat surface for the dermatome.

The old-fashioned hand-operated dermatome is something else again: It not only cuts the strip of skin but also picks it up and holds it on a glue-coated metal drum that moves along behind the blade.



HYDROTHERAPY: *Daily baths are begun as soon as graft sites are sufficiently healed to be treated by exposure. Here the nurse administers passive exercise to help restore muscle tone and prepare the burn victim for ambulation. Baths also keep the grafts clean.*

As the skin is sheared from the donor site, it is dropped into a basin of warm saline. The nurse then removes it, a strip at a time, and prepares the grafts.

To do this, she lays each strip, raw side up, on a piece of gauze bandage that has been lightly impregnated with petrolatum. Then she puts the gauze on a board and smooths out the skin strip, pressing it firmly against the petrolatum gauze so it won't wrinkle or curl. Next, she trims away any excess gauze, folds the strip in half (gauze side out), and wraps it in a wet pad, ready for use.

(The petrolatum gauze has been prepared earlier by placing a roll of three-inch gauze in a pint jar, adding white petrolatum until the jar is one-third full, and autoclaving. The result is an easy-to-handle roll of gauze with just the right amount of petrolatum adhering to it.)

Any skin strips left over after the grafting can be stored in sterile jars containing 30 ml. nor-

mal saline, 0.5 gm. streptomycin, and 300,000 units penicillin. They will keep that way in an ordinary refrigerator for about seven days. Grafts that must be kept for a longer period have to be dried thoroughly, folded together on plain dry gauze, wrapped in a sterile cover, and stored in a freezing unit.

Use of the Reese dermatome (a variation of the drum dermatome) eliminates fixing the skin strips to petrolatum gauze. This instrument's drum is coated with green, rubberized material that adheres to the skin strip and serves as a backing when the strip is removed from the drum. This backing is left on the strip when the graft is applied to the burn wound. Several days later, when the dressing is changed, the backing falls off.

Troublesome Areas

Ordinarily, a graft is simply laid on the wound and bandaged into place. But those applied to neck, elbows, or other areas where body movements might disturb them are usually sutured with 4-0 silk.

When there is a sizable burn wound and only a limited amount of tissue, either of two procedures may be followed: (a) one-inch-square pieces of skin ("postage-stamp grafts") are spread over the wound surface about one-half inch apart; or (b) small strips of homograft and autograft are applied alternately to the wound.

One-Shot Procedure

In either case, epithelium grows outward from the autograft and eventually covers the whole surface. And in either case, there's this twofold advantage: The grafting can be completed in one operation and at a time when the burned surface is best suited to receive a permanent graft.

Donor sites invite contamination. Many burn victims have, of course, died because of infection, or failure of donor sites to heal. So the choice of dressing is a serious one. The best method, and the one most surgeons now use, is to cover the new grafts with Brooke Burn Dressings and to treat the donor sites by exposure.

Dressing Donor Sites

If the surgeon chooses to expose the donor sites, here's what he does: As each strip of skin is

removed by the dermatome, he covers the freshly denuded area with a piece of dry roller bandage. Then he puts wet pads on top of this to halt surface bleeding.

Just before the patient is ready to leave the O.R., the surgeon removes these wet pads, leaving the strips of blood-soaked roller bandage in place. In about twenty-four hours, these strips will have hardened into a firm protective covering. The donor site will eventually heal under this covering; then the covering will fall off.

How You Can Help

Back on the ward, the patient is kept on his Stryker frame until all donor and recipient sites have healed. He'll need narcotics for the first twenty-four hours at least—for we must keep him comfortable until the grafts have begun to "take." And for the next two or three weeks, he'll need two important services from you, his nurse:

1. Careful observation for any signs of infection. Infection of exposed donor sites is unusual except in those areas where body movements might crack the protective surface. But infection of covered donor sites is common.

2. Close attention to good nutrition. This is no time to neglect spoon-feeding. Be sure your patient's meals are warm and appetizing. And make certain he gets plenty of high-protein, high-calorie liquids. For he's not out of danger yet—and won't be until his grafts and donor sites have all healed and he's up walking around.

Back on His Feet

The dressings on his grafts are changed every three to five days for about two weeks. Then the grafts are exposed and hydrotherapy is begun. This keeps his wounds clean and prepares his long-unused muscles for action again.

You can now move him from his Stryker frame to a regular bed. This gives his morale a tremendous boost. From this point on, you'll see a remarkable change in his behavior and personality. He'll be eager to eat, walk, and exercise.

Patients with extensive third-degree burns need a great deal of attention that doctors just can't give. So, much of the responsibility for the recovery of the burn victim falls on you. END

F.U.O.

a pediatric whatdunnit

One of the most baffling conditions the nurse must investigate—one calculated to bring out the Sherlock Holmes in any R.N.—is fever of undetermined origin in children. This long-experienced pediatric nurse tells you how to detect its cause

By Cecilia L. Schulz, R.N.

A giant-size mystery in a pint-size patient confronts the staff of our pediatric ward whenever we get a child with fever of undetermined origin (F.U.O.). The title of this mystery might well be "The Case of the Dangling Diagnosis." And it's a challenging one, replete with suspense—a *what*dunnit that calls for a nurse-sleuth who can recognize clues and act swiftly.

For the F.U.O. on the child's roster card may be the first clue to a five-syllable malady.

Suppose (as often happens) the malady's more revealing symptoms don't appear for several hours. By then, the doctor who examined the child may be miles away—perhaps making house calls. The need for prompt action by the nurse is urgent.

The moment she spots a significant new symptom (or a change in the child's condition), she phones the doctor. By so doing, she paves the way for (1) a speedy re-examination; (2) a specific diagnosis while the ailment is still in an early stage; and (3) through prompt treatment, a head start toward recovery.

Now let's pause to refresh, reviewing briefly some significant facts about fever in small fry:

First of all, it comes in two "lengths": (1) short-term fever and (2) long-term fever.

Short-term fever is often the sudden, skyrocketing type associated with acute infectious disease. Long-term fever—low-grade or otherwise—is more likely to be associated with a chronic ailment.

Generally speaking, few short-term fevers come to our ward with an F.U.O. label. Why? Because they're usually accompanied by trimmings that make the cause relatively easy to spot.

A child, for example, who blossoms out in a rash and develops diarrhea or vomiting (or a runny nose, swollen glands, a croupy "bark," or the like) has already had his malady diagnosed—and there's no F.U.O. about it.

But every so often the telephone clangs and we're told to ready our bailiwick for a child who does have F.U.O. When that happens, here's what we do:

While still on the phone, we ask the child's age. For that's what governs the type of bed to be readied: isolator, incubator, bassinet, crib, youth bed, or large bed.

Age also suggests what ap-

parel to have ready. Will it be diapers and safety pins? Or a suitably sized gown for a member of the post-diaper set?

Since the ultimate diagnosis could be in the communicable category, we make plans to isolate the child. Because anything can happen (and often does) with F.U.O., we also check to see that we're prepared for oxygen therapy.

No Last-Minute Rush

Naturally we do whatever bed-moving (or flying around) is necessary before the patient arrives. The idea is to avoid any suggestion of urgency while he's being bedded down. Even if he's too young to appreciate a smooth reception, it may lessen his parent's anxiety.

If our newcomer is an infant, we have the wherewithal handy to tape him for a routine urine specimen: a glass bird-feed cup containing two cotton balls, and three strips of adhesive for anchoring purposes. (Of course, we secretly hope that insertion of the rectal thermometer will induce voiding and thus obviate need for the barbaric taping procedure. Should this hope materialize, we put the feeding cup pronto in the spot where it will do the most good.)

If our newcomer is an older child, we make sure the proper size bedpan or urinal bottle is within reach for his "command performance."

In the case of an infant with F.U.O. being transferred from the OB nursery, we know the doctor in charge has already ruled out two fevers of *determined* origin that are common among the newborn: (1) "inanition fever," caused by dehydration; and (2) "artificial hyperpyrexia," caused by overzealous roasting in a too-warm nest.

As a rule, the infant's doctor wants to investigate the possibility of meningitis. So we ready the necessary examining table, spinal-tap tray, gloves, and solutions. We also understand the importance of getting signed permission from a parent or guardian before the technique is begun.

Next our infant gets round-the-clock observation. We're on the alert for a bulging or distended fontanel; for shrill, high-pitched cries; for drowsiness, alternating with irritability; and for nuchal rigidity.

In an older youngster with

F.U.O., we check for such symptoms as drowsiness, vomiting, ocular palsies, tremors (or any jerky movements), photophobia, coma, urine retention, nuchal rigidity, arched back, bleeding, weak or irregular pulse, unstable blood pressure, respiratory distress, cyanosis, convulsions, and unequal pupils.

Usually, the doctor gives us some inkling of what the ultimate diagnosis may be. He also cites specific symptoms he feels may develop. These we watch for especially. But note: We check frequently for *any* untoward sign, *any* bizarre symptom.

For fevers of 103 degrees or more, the M.D. usually orders cool-water sponges and cool-water enemas q.4h.

The doctor may also order an antipyretic, taking into consideration any known allergies

"I think I overdid the T.L.C."

the child may have. Dosage depends on the patient's age and body weight. If the child is unconscious or unable to retain fluids, the dose may be given rectally.

At times, antibiotic therapy is started while fever is high. But some physicians defer it, lest it mask any developing symptoms.

F.U.O. patients whose pyrexia persists for a long period include those likely to have rheumatic fever without any joint pain, extrapulmonary TB, osteomyelitis with no local manifestations, and paranasal sinusitis with pyrexia as its principal symptom.

Others with F.U.O. in our pediatric realm (often the most heartbreaking) turn out to be children suffering from leukemia, Wilm's tumor, lymphosarcoma, sickle cell anemia, and Cooley's anemia.

Now a word about the nurse-patient and nurse-parent relationships as they apply in F.U.O. cases.

How Mother Can Help

We find it helpful at admission time to have the mother undress the child. The mother is better off when thus occupied and the child is less likely to be frightened. Meanwhile, we can observe the youngster and ask the mother a few questions. We need to know:

¶ The child's weight—in case anesthesia is required, or fluid intake needs balancing.

¶ Whether or not he has any food or drug allergies.

¶ His pet nicknames, if any.

¶ Whether or not he has been baptized.

¶ Whether or not he's potty trained, cup trained, a belly sleeper, a pacifier user, etc.

In asking such questions, we avoid the ping-ping-ping approach. Between queries we sandwich in a casual remark or two—such as something nice about the youngster's behavior. We want our manner and tone to show that the child is among friends. We want to reassure and calm the mother by displaying an unstarched, woman-to-woman neighborliness.

Diagnosis is not, of course, within our province. But a keen interest in every F.U.O. is. So, without violating the code of ethics, we invariably ponder the whys and wherefores of the case as this medical mystery is unraveled before our eyes. Our value as nurses is enhanced accordingly. END

Your Patients Can Widen Your World!

BY JANICE CAMPBELL, R.N.

In my second year of training, it dawned on me one day that I had fallen into a typical, unimaginative conversational rut. I realized how weary my patients must be of my routine chit-chat about the hospital food, recent movies, TV shows, and that most desperate topic, the weather.

I resolved to do something about it.

* * *

One of my less cheerful patients, a Mr. Carter, in 904, was to get a bed bath that morning. So I studied his chart beforehand for clues to subjects that might interest him. An entry on his admission sheet caught my eye: "Occupation—gilder."

One of the few articles I'd read up to that point happened to be about gilders. It mentioned how they work with gold leaf often no more than four-millionths of an inch thick! But I still had some unanswered questions about this unusual trade.

While giving Mr. Carter his bed bath, therefore, I

THIS ARTICLE *has won one of the* 1958 RN *Awards for its author, a part-time nurse in Hartford, Conn.*

told him about the article I'd read and asked him if he'd mind enlightening me on a few points. This glum man of few words brightened visibly. He'd be "more than happy," he said, to answer any questions I might have.

Time Flew

From his room we could see the dome of the state capitol, which he had helped to gild. I listened fascinated as he told me about it. Time passed so quickly, in fact, that the bed bath was finished and the room tidied up before I realized it.

My patient was as a statue come alive. I couldn't get over the transformation wrought by the chance he'd had to discuss something that interested him. Nor could I help being impressed by the pleasure and knowledge I'd gained as he talked.

Then there was Mr. Davis, in 912—a finicky patient whom everyone found hard to please. While giving him his morning care, I mentioned that I was getting poor snapshots from my box camera, even with a new yellow filter.

"I noticed that you're a commercial photographer," I said. "If you have any suggestions, I'd really appreciate them."

Mr. Davis soon forgot himself and his troubles and opened up like an old friend revisited. "Well now, you see, with a box camera . . ."

I gained several valuable pointers from his lively discussion of photography, and he was patently pleased to be able to help me. Later, when he was discharged, he gave me a manual on "How to Take Good Pictures."

A Blooming Friendship

One winter I had trouble getting a new gardenia plant to bloom. A chat with one of my women patients, a florist, yielded several good suggestions. I followed them, and soon my plant blossomed.

Both the patient and I were delighted. She gave me her card and urged me to call her any time I had a question about plants or flowers.

Informative and entertaining conversations with patients can just as readily be *your* daily fare. Consider some of the possibilities:

Mr. Gardner, that coronary patient, is the policeman who caught a local thief last year.

Mr. Lane is a real estate agent. Mr. Richards is a cab driver who plans to write a book about his experiences.

Curious about the stock market? Mr. Barrett is a retired broker.

Mr. Lawrence owns a butcher shop. He'd enjoy telling you how to select the best and most economical cuts.

When a patient can be encouraged to talk about his job, both he and his nurse profit. The patient enjoys a real boost in his morale as he's given a chance to help or inform or entertain the nurse assigned to him. The nurse, in turn, becomes a better-informed person as she develops the art of conversation along with her nursing art. END

Vocal therapy

For three days, I had specialed him in silence. My 40-year-old patient—victim of a severe stroke—had been unconscious the entire time.

On the third day, for lack of anything else to do, I began pinning his "get-well" cards to the bedside screen. As I did so, I came upon one of those bizarre, off-beat cards that caused me to burst out laughing.

The next thing I knew, my patient had opened his eyes and was staring at me. Impulsively, I reached for a toy basset-hound the patient's 4-year-old daughter had brought him, and anchored it to the bedrail. I explained that Barbara wanted it there to supervise his recovery.

Before closing his eyes again, he smiled faintly but unmistakably.

Some months after his recovery, he told me something I've never since forgotten. It made me realize how much the sound of a nurse's voice can mean to a patient—even to one who's not fully conscious.

"The fog seemed to lift," he said, "when I heard you laugh and mention Barbara's name and when I saw that incredibly silly-looking pup at my side." —FRIEDA SCHWARTZ, R.N.

How We Handle Eye Emergencies

Two industrial R.N.s draw on their experience with victims of eye injuries to offer you some practical do-and-don't advice

By Patricia D. Horgan, R.N.

Excited voices drown out the workaday sounds around you. Seconds later, two men rush up to you, supporting another man between them. He's hunched over almost double. His trembling hands are pressed against his cheeks. Water on his hair and face drips to the floor.

"Acid . . . sprayed up . . . all over him . . . He can't see," one of the men stammers. "Please, nurse, do something."

You quickly pit your nursing skill against the acid. A man's sight hangs in the balance . . .

* * *

To report to you on the latest procedures for handling eye injuries, *RN* assigned me to interview two industrial nurses whose work gives them broad experience with such injuries: Ann Barnard of the Electric Boat Division of General Dynamics Corporation, Groton, Conn., and Kathryn Fullaytor of Stratos, a division of Fairchild Engine and Airplane Corporation, Bay Shore, N. Y. Here are their suggestions:

First, calm the victim and get him where you can examine his eye. "He may be excited," says Mrs. Fullaytor. "But you don't allow *yourself* to become excited too. Your reaction to an injury must convince the patient that you have the situation well in hand."

Miss Barnard admits that "you may sometimes be tempted to exclaim, 'Wow!' But you don't do it." Instead, she suggests, you clear the room of sympathetic bystanders and, when the patient is more relaxed, you examine his eye to determine the nature and extent of the injury.

Because an injured eye is highly susceptible to infection, both R.N.s interviewed stress the need for strict asepsis when examining it. Here is what Mrs. Fullaytor does before she even touches an injured eye:

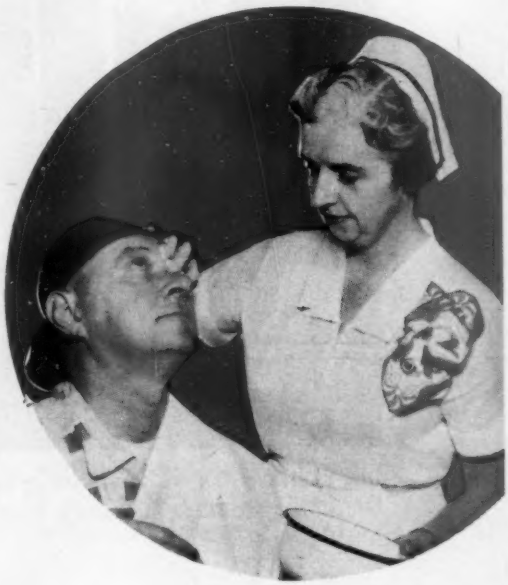
She adjusts the light for the examination. She washes her hands. She gathers material she thinks she'll need (such as applicators, medications, irrigating solutions, eye patches) and handles it aseptically. Then she washes her hands again.

These things done, she gently turns the upper and lower eyelids outward. She is careful not to exert any pressure on the eyeball that would cause further damage.

"Let's say it's a foreign body such as dirt, dust, or a piece of metal," she explains. "I take a long, careful look with a good light and magnification. When I've found the object, I use a bulb syringe to flush the eye with sterile saline or boric acid solution.

"In the event that the foreign body doesn't float out, I moisten a sterile applicator with saline and gently brush it away from the center of the eye toward the temple. I do this *once*. If the foreign body isn't out by then, I send the patient to an ophthalmologist."

Mrs. Fullaytor emphasizes that in cases where these simple



KATHRYN FULLAYTOR *applies a cold compress to the eye of a worker suffering from "welder's flash."*

measures do not remove the foreign body, the nurse must discontinue her efforts. Further attempts may lacerate the delicate eye tissues or drive the object into the eye. Above all, she warns, *never* try to remove an embedded foreign body, even if it's protruding from the eye.

"Speed is the important thing when the eye is burned by a chemical," Miss Barnard says. "We start irrigating the eye immediately with the first available source of water—whether it's a pitcher, a sink faucet, or even a bucket of water in which the victim can douse his head (of course, with his eyes open). Later, in the medical unit, I instill a few drops of eye anesthetic to relieve the lid spasm, and I irrigate the eye with sterile water for at least fifteen minutes.

"The key word is irrigate . . . irrigate . . . irrigate. The more a chemical is diluted and flushed out, the less chance of serious and lasting damage to eye tissues."

For lacerations, wounds, or penetrating injuries of the eye, both nurses agree on this advice: Cover the eye with a sterile eye

ANN BARNARD *helps the victim of an eye accident into the Electric Boat Division's Mobile Emergency Unit.*

patch. Tell the patient to lie flat and not to move his head. Get him to an eye specialist without delay.

Miss Barnard recalls a day at the shipyard when a young worker was brought to the yard hospital in shock and with a severely lacerated eye. He had been skinning a wire cable with a knife. Unfortunately, he wasn't wearing his safety goggles. As he drew the knife toward him, it slipped off the cable and pierced his eye.

No Time to Lose

"I took one look at the wound," Miss Barnard says, "and called the company's emergency truck. Almost before I hung up the phone, the truck was at our door and we were on our way to the doctor in New London. Fortunately, quick action saved the day—and the worker's eye."

Says Mrs. Fullaytor: "When in doubt, send the patient to an ophthalmologist. Don't attempt too much yourself, especially if you're not sure what to do. For instance:

"Unless antibiotics have been specifically ordered by the doctor, don't give them; for their indiscriminate use may increase the danger of secondary infection. The thing to note here is that the staphylococcus and streptococcus organisms normally found in the eye are weakened by the antibiotic. This allows other bacteria, introduced during the eye injury, to grow unchecked.

What About Cortisone?

"I'm equally cautious about using cortisone. It retards the healing of abrasions; and when they're left open they may become infected."

To avoid the temptation to give more than simple first aid, the industrial nurse works with a minimum of equipment. You won't find an instrument on her treatment tray—not even an eyecup. Her only stock solutions are distilled water and normal saline. She has few stock medications.

She's a Teacher

Teaching is often her most effective therapy. Take, for instance, Miss Barnard's experience with the industrial injury called "welder's flash." This "sunburn" of the eyes is caused by ultra-violet radiation when a welder's arc is struck. *More*▶

The patient has no pain at first, but several hours after the flash of white light occurs, he complains of "hot sand" in his eyes. Often, he fears that he's going blind.

"I hear so many strange remedies for this, like bathing the eyes with milk or laying a potato on them," says Miss Barnard, "that I have to explain repeatedly how such home remedies may not only be useless but may actually favor infection or cause further injury. A cool compress is really all that's generally needed to relieve the discomfort."

It's well to be prepared for eye injuries and to remember that old saying: "The light of the body is the eye." For when an injury threatens to extinguish this light in anyone, your skill may be the only thing between him and external darkness. END

Shabby cabby

Late one winter afternoon, my sister and I (both nurses) waited for a bus to take us to our evening stint at the hospital. It was bitterly cold. My sister shivered even in her then-popular raccoon coat.

But no bus came in sight.

Not only were we freezing; we were also in danger of being late—which worried us considerably more than the temperature. So I hailed a passing cab.

"To the Woman's Hospital . . . and quick," I shouted, reaching for the taxi door handle.

One look at my sister's bulky raccoon coat and the driver's eyes popped.

"Nothin' doin', lady," he cried as he stepped on the gas, "—not in *my* cab!"

At least we were so shaken with laughter by this that we stopped shaking with cold. —JESSIE A. BARFORD, R.N.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address:* Anecdotes, RN, *Oradell, N.J.*

New Drugs for High Blood Pressure

BY MORTON J. RODMAN, PH.D.

"Learn to live with it." That's about all a doctor could tell a patient with high blood pressure a dozen years ago. Today, things are different. Drugs introduced in the past decade can keep most cases under control.

But there has been one major drawback: In some patients, these remedies have caused severe side effects. So, many people—unwilling to pay this price in order to keep blood pressure at safe levels—have stopped taking the drugs.

That's why we may well familiarize ourselves with several new drugs just made available.

These newcomers differ from each other in the way they work. But they have one thing in common: They can be given in doses that bring pressure down with a minimum of ill effects.

Let's see how doctors are combining these newest agents with older drugs for best results.

Syrosingopine (Singoserp) is a synthetic relative of reserpine and other Rauwolfia alkaloids. Like the latter, it suppresses the flood of constrictor impulses that flow from brain to blood vessels. But it does so without interfering with other functions.

Natural Rauwolfia alkaloids cause many ill effects—some mild (like a stuffy nose or stomach upset), others serious (such as severe mental depression). Patients on reserpine have even attempted suicide because the drug depressed them emotionally.

Syrosingopine seems to have only a fraction of reserpine's sedative or tranquilizing action. So far, few patients getting it have become drowsy or depress-

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J.*

ed. In fact, some have become brighter and more alert when switched to syrosingopine from natural Rauwolfia products.

Like its relatives, syrosingopine works best in the milder forms of hypertension. But it can also be combined with more potent agents to treat severe cases. When it's given with hydralazine (Apresoline), for example, the dose of the latter can be lowered.

This is important; for while hydralazine helps to relax constricted vessels and hits at blood-pressure-raising hormones, many patients who start on the drug soon quit because they can't take its side effects (headaches, dizziness, cardiac palpitations).

"Homemade fudge in 408."

Syrosingopine has a pulse-slowing action that counteracts the tachycardia caused by hydralazine. It curbs other side effects, too. Some cases resistant to each agent alone have benefited from their combined action.

Syrosingopine has also been used successfully in tandem with the Veratrum alkaloids. The latter are useful drugs, but they tend to cause nausea and vomiting. Syrosingopine helps prevent this; for when it's combined with the alkaloids, the latter may be given in smaller, less nauseating doses.

Recently, scientists have isolated a single alkaloid from veratrum. This crystalline substance, protoveratrine A (Protalba), is said to have a wider safety margin than mixtures of veratrum alkaloids. So treatment of pregnancy toxemia and other acute hypertensive states may be safer and more effective from now on.

Another newcomer, chlorothiazide (Diuril), also helps to get more mileage out of older drugs. When patients are primed with chlorothiazide for a few days, the M.D. can cut down dosage of the more dangerous older drugs and still get a satisfactory drop in blood pressure.

How chlorothiazide makes this possible isn't entirely clear yet. It was first used as a diuretic for draining salty fluids from edematous tissues. So the basis of its effectiveness against high blood pressure may be its ability to lower salt levels.

The fact that the older drugs can be given in reduced dosage when combined with chlorothiazide is especially important in the case of the ganglionic blocking agents. These drugs are highly effective against the most severe forms of hypertension (including the once rapidly fatal "malignant" type). But their usefulness has been limited by their side effects. Full doses given to block transmission of constrictor impulses through sympathetic ganglia have deadened parasympathetic ganglia, too. This has led to blurred vision, dryness of mouth and skin, urinary retention, and severe constipation.

Now the addition of chlorothiazide makes it possible to cut the dosage in half. This means that the arterioles dilate and blood pressure falls at doses well below those that block transmission of parasympathetic impulses.

Of course, blood pressure reduction itself may cause side effects. And chlorothiazide may increase those effects.

Postural hypotension is an example. Here, an almost-inevitable feeling of weakness and dizziness plagues patients when they stand up suddenly. Why? Because the drug prevents normal pressor reflexes from shunting blood to the brain.

Some doctors think this can be avoided by adjusting dosage very carefully. And because the spacing of dosage is largely up to the patient, these doctors have been teaching him to take his own blood pressure. This is contrary, of course, to the old notion that the patient shouldn't be told anything about his blood pressure. But it does give him a better idea of when to take his medicine.

Some day, we'll have drugs tailored specifically to each patient. Then, perhaps, there will be no side effects. But first we must learn more than we know now about the causes of high blood pressure.

We can be grateful, meanwhile, for the advances made so far. The new hypertension drugs may not get at the underlying cause of the condition. But they do make it safer and easier to manage.

More▶

Drugs That Low

Drugs Acting on Central Sympathetic Areas

Rauwolfia Alkaloids and Analogues

Official or Generic Name	*Trade Name or Synonym*
Rauwolfia serpentina (whole root), N.N.D.	Raudixin, Rauserpa, Rauwal, et al.
Alseroxylon, N.N.D.	Rauwiloid, Rau-Tab, Rautensin, et al.
Deserpidine, N.N.D.	Harmonyl
Rescinnamine, N.N.D.	Moderil
Reserpine, N.N.D.	Serpasil, Sandril, Serfin, Serpiloid, Serpate, Serpine, Serpanray, Rau-Sed, Raurine, Reserpoid, Rauloydin, Roxinoid, et al.
Syrosingopine	Singoserp

Veratrum Viride and Veratrum Album Alkaloids

Alkavervir, N.N.D.	Veriloid, Vergitryl
Cryptenamine acetates, N.N.D.	Unitensin acetates
Cryptenamine tannates, N.N.D.	Unitensin tannates
Protoveratrines A & B, N.N.D.	Veralba
Protoveratrines A & B maleates, N.N.D.	Provell maleate
Protoveratrine A	Protalba

Drugs Acting at Autonomic Sites

Ganglionic Blocking Agents

Chlorisondamine chloride, N.N.D.	Ecolid

ood Pressure

Official or Generic Name	*Trade Name or Synonym*
Hexamethonium chloride or bromide, N.N.D.	Bistrium, Esomid, Hexameton, Methium
Mecamylamine HCl, N.N.D.	Inversine
Pentolimium bitartrate, N.N.D.	Ansolysen
Tetraethylammonium chloride, N.N.D.	Etamon
Trimethaphan camphorsulfonate	Arfonad
Azamethonium chloride	endiomide

Adrenergic Blocking Agents

Azeptime	Ilidar
Phenoxybenzamine HCl	Dibenzyline
Phentolamine HCl and methanesulfonate, U.S.P.	Regitine
Piperoxan HCl, N.N.D.	Benodaine
Tolazoline HCl, U.S.P.	Priscoline

Drugs Acting on Vascular Smooth Muscles

Sodium nitrite, U.S.P.	
Erythrityl tetranitrate, N.F.	Erythrol
Inositol hexanitrate	Tolanate
Mannitol hexanitrate, N.N.D.	Mannitol, Mexitate, Nitranitol

Drugs Acting in Miscellaneous Ways

Chlorothiazide	Diuril
Hydralazine, N.N.D.	Apresoline
Hydrogenated ergot alkaloids	Hydergine
Potassium sulfocyanate, N.F.	Potassium thiocyanate
Sodium nitroprusside	

END

NURSING SUN VALLEY STYLE

WORLD-FAMED SKIING *lured six out of Sun Valley Hospital's eight R.N.s to their present jobs there. The skiers alternate on twilight and night shifts so as to have plenty of daylight hours for their favorite sport. Other off-duty interests include figure skating, bowling, and photography.*

THERE'S WORK APLENTY, *too, for Sun Valley's nurses. Says Carol P. Lightfoot, shown here with a tiny patient: "In this small, well-run hospital I use all the techniques I ever learned, plus a few new ones!" Births—sixty-five last year—are increasing, while skiing accidents are decreasing. Most unusual patient: a wounded antelope.*

SPECIAL ASSIGNMENT: *It was a thrilling experience for Carol (center background) to go on location with Lucille Ball and Desi Arnaz when they made a TV film at Sun Valley last winter. Heather Baker, another Sun Valley R.N. (not shown), had fun, too; she was a figure-skating extra in the film.*

GRAND CLIMAX *to Carol's Sun Valley experience was marriage to Douglas, shown here cutting their cake at a reception at romantic Trail Creek Cabin. Heather Baker was married recently, too. Both newlywed couples have deer meat in their deep freezers, bagged on fall hunting trips.* END

LEPROSY – FABLE

Here's the plain—yet surprising—truth about this age-old disease. And here's what you can do to help banish public superstition about it

By Josephine Bartsch, R.N.

● Yellow flames enveloped the timbers of an abandoned house in California. Police and firemen were burning it as a menace to the community. For years it had crumbled with disuse because no one would enter it—let alone live there. Reason: Its last occupant was said to have had leprosy . . .

● Sophisticated and hard-bitten New Yorkers filed hurriedly from a courtroom. A moment later, the judge declared a recess (he had just remembered a pressing engagement). How come? The next witness was a woman rumored to have leprosy . . .

● A "Closed Today" sign hung on a Texas schoolhouse. Inside, workmen scrubbed and fumigated classrooms and halls. The public had clamored loudly for this. The reason: Gossips had spread a report that a student had contracted leprosy . . .

● Irate citizens in Lousiana burned a lovely old colonial mansion to the ground. Why? They'd heard the Government planned to use it as a leprosarium . . .

These aren't incidents from the Dark Ages. All of them happened in the present century, right here in the United States.

They could not be called typical of public attitude now, in 1959. For some progress has

A familiar figure in the Middle Ages, the wretched leper was obliged to sound his clapper as a warning to wayfarers.

been made in educating people to take a more scientific approach toward leprosy. Yet the fact remains that the disease still fills the minds of men with fear and superstition.

Much of this apprehension is groundless in the light of present-day knowledge. Leprologists say that while the disease *is* communicable, it's often far less contagious than, say, tuberculosis.

True, there's still no known cure for leprosy. But it *can* be controlled. The sulfone drugs—Diasone, Promin, Promizole, for example—have been used successfully for about seventeen years to arrest it. Most persons receiving such drugs become noninfectious and don't need isolation in a special hospital.

This being so, a person with leprosy could be treated as an out-patient at your local hospital. Or he could be admitted to the communicable disease ward. But, ten to one, his admission would create anxiety even among the staff.

A ward nurse in a large hospital that admitted a leprosy patient says, "A staff doctor ordered us to wear two isolation gowns, gloves, and a mask. He even insisted on using a separate stethescope to examine the patient. We were all pretty worried . . ."

Actually, the only precaution needed is the same meticulous aseptic technique employed for any communicable disease. At least that's the basic rule at the U. S. Public Health Service Hospital in Carville, La. *And not a single member of its professional staff has contracted leprosy in sixty-one years!*

In a typical day at Carville, an R.N. may administer medications, assist with treatments, do passive exercises for a weakened bed patient, and dress foot ulcers. She sees fewer and fewer chronically and terminally ill patients, now that the sulfone drugs are in use. But she knows there's still one big obstacle blocking each patient's rehabilitation: the fear and revulsion the public feels toward the person known to have leprosy.

Carville's ex-patients tell heart-breaking stories of social ostracism. One man's barber refused to shave him when he came home from the hospital. Another ex-patient was unable to get a job (or even to buy groceries) when neighbors learned he'd been treated for leprosy.

These and countless other cases prove that the nurse's help is badly needed in putting across two ideas: (1) Leprosy *can* be arrested with drugs. (2) It's just another infectious disease.

You can do much to educate the public by giving simple, straightforward answers to commonly asked questions. Thus:

What is leprosy? It's an infectious disease that strikes the whole body but especially the skin and nerves. It occurs only in humans. (The warm climate of Southern states seems to favor it.) Immigrants from Asia and Africa are believed to have carried leprosy originally to the U.S.

What causes it? A bacillus, mycobacterium leprae. This organism is *always* present in patients with the disease, rarely in healthy persons.

How is leprosy spread? By prolonged and intimate contact with a person who is actively discharging bacilli—a patient with the "open" or [*More on 90*]

"It's her first operation."

OCCUPATIONAL TINTYPES

BY B. Wiseman

The patient's view of the nurse

The nurse's view of the patient (that new male one)

The probationer's view of the nurse

The supervisor's view of nurses

The nurse's view of probationers (when her back's turned)

An RN *Refresher:*

The Stryker Frame

These key facts will refresh your memory about the frame and how it simplifies patient-care

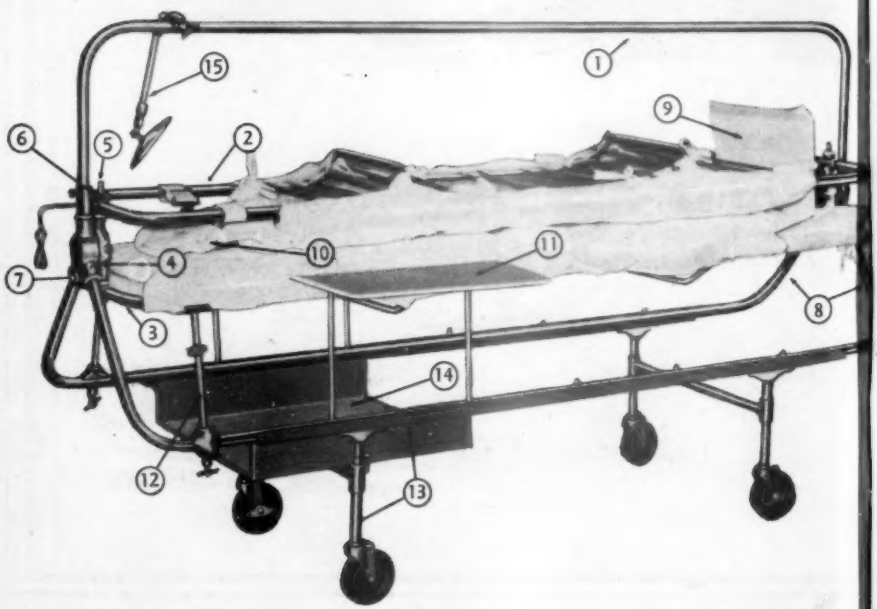
By Mary Tuomey, R.N.

At first glance, the Stryker Turning Frame looks like a glorified stretcher. But any R.N. who's ever used one knows it's much more than that: It's a first-class patient-aid as well as a nurse-saver.

The Stryker frame makes nursing care infinitely easier by enabling the R.N. to turn her patient to either the prone or supine position, without help and without effort on his part.

As a result, it's relatively simple to bathe, toilet, and give skin and back care to a person who's

THE STRYKER FRAME IN DIAGRAM: (1) overhead rod; (2) anterior frame; (3) posterior frame; (4) pivot device; (5) bolt; (6) lock nut; (7) spring lock; (8) support runners; (9) foot support; (10) face support; (11) arm support; (12) stabilizer arm; (13) cart; (14) utility tray; (15) mirror.



immobilized or helpless. Treatment, too, is facilitated. And so is bedmaking.

The ease with which the nurse can change the patient's position also means she can do it often. And this helps prevent the well-known complications that so often go hand in hand with prolonged bed rest: pneumonia, decubitus ulcers, muscle contractures, foot-drop, and wrist-drop.

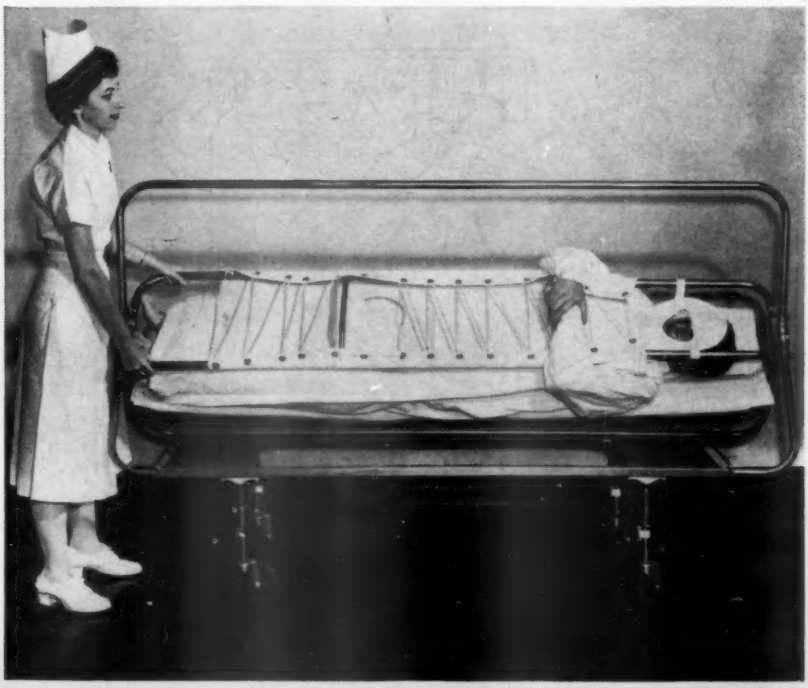
The Stryker frame—a modified form of the familiar Bradford frame—has five basic parts:

1. An anterior (prone position) frame fitted with a canvas face support, a canvas cover with a perineal opening, and a mattress.

2. A posterior (supine position) frame fitted with a canvas cover and a mattress. (Cover and mattress are each in three sections, the sections under the patient's buttocks being movable for toileting.)

3. A four-wheeled, cartlike chassis to which a pair of tubular support runners are bolted. (The runners curve upward toward

TURNING A PATIENT UNAIDED: One nurse, alone, can do it. She simply sandwiches the patient between the anterior and posterior frames of the Stryker unit, then rotates him from back to abdomen, or vice versa.



each other at each end of the cart.)

4. A pivoting device at each end. (This incorporates the "axle" on which the frames turn and the "hub" into which the support runners are locked.)

5. Accessories. (These include an overhead exercise rod; arm supports that fit onto the runners; and a utility tray for the patient's food tray, books, etc.)

Here's what the nurse does when she wants to turn a patient from supine (on his back) to prone (on his abdomen):

¶ She locks the cart wheels and removes the arm supports.

¶ She levels off the contours of the patient's body with pillows so he'll be sandwiched securely between the anterior and posterior frames. (A pillow placed lengthwise over his legs is especially important to prevent them from slipping out while he's being turned.)

¶ She places the [*More on 92*]

"Why, it's a sympathy card from your wife—for *me*!"

I've Found New Satisfaction as an R. N.

You—like the author—can have fun, stay young, and aid a fine cause by being an adviser to a future nurses club

By Leona Harrang Hall, R.N.

Looking for the ideal nursing job?

Well, I can't help you on *that* score.

But I can suggest a way to get more enjoyment, more stimulus, and more of a sense of accomplishment out of life.

How? By acting as an adviser to a future nurses club.

As you know, such clubs are composed of high-school students interested in a nursing career. And the enthusiasm they generate is a tonic for jaded spirits. It can boost your professional ego like almost nothing else and give you a soul-satisfying experience you'll never forget.

I know. For I've been the R.N. adviser to the Wallace (Idaho)

FUTURE NURSES *of Wallace, Idaho, round out their annual trip to Spokane, Wash., with a visit to Fairchild Air Force Base Hospital. Among other stops: a large metropolitan hospital, a blood center, and a health center. They even managed to squeeze in a bit of shopping.*

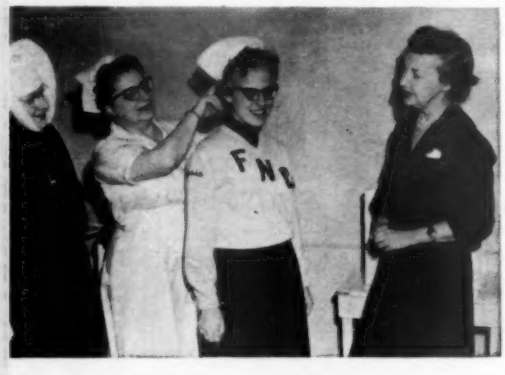
Future Nurses Club for nearly four years.

I've enjoyed the activity so much, in fact, that I'd like to share it with you:

I first became interested in the movement when a doctor's wife happened to mention it to me. Like you, I had heard that such clubs were springing up locally all over the country. But I knew little about what they do and still less about organizing one.

When I wrote to the Committee on Careers of the National League for Nursing, the literature they sent me indicated that future nurses clubs got their national start about 1950. Since then, they've experienced a truly phenomenal growth: At last count, the country had about 2,500 such clubs, with some 80,000 members.

I also learned that most of the clubs develop independently, and are individual in character; yet they are alike in purpose. They



A PERFECT FIT. *Club Adviser Leona Hall,* R.N., *steps back for an appraising look as High School Senior Eldora Day tries on a student nurse's cap at Wallace's Providence Hospital. Alice Agarla,* R.N., *lends a hand as Sister Magdaline of Providence smiles approval. Next year it will be for real!*

enable teen-agers interested in nursing to share that interest, to explore the profession's opportunities and requirements, and to learn about community life. From organized nursing's viewpoint, of course, the club idea is a boon to recruitment.

The more I discovered about the movement, the more I realized what a marvelous opportunity it offered me, as an R.N.: By helping to start a local club and by serving as its adult adviser, I could make a real contribution to my profession.

The formation of a club, I learned, requires the sponsorship of some civic group, such as the women's auxiliary of the local medical society. (N.L.N. sponsors the clubs nationally.) I was fortunate in finding an enthusiastic sponsor in *our* women's auxiliary.

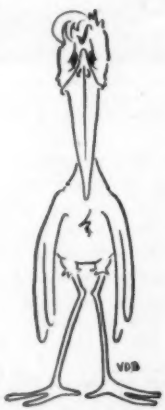
When I had all the necessary facts and the required sponsorship, I discussed the project with the high-school principal and got his approval. (It's essential to have such approval because of the extracurricular nature of the club. Some schools already have so many after-hours activities that one more just isn't advisable.)

In the fall of 1955, our club became a reality. Its fifteen members now meet twice a month—sometimes at school during the noon hour, sometimes at my home in the evening.

Experience has taught me that it's wise to keep the membership small. A large club with lots of "happy joiners" but no real interest is doomed to failure.

As the club's adult adviser, I help its members plan their activities. These include meetings, trips to hospitals, actual participation in hospital work, and such community projects as "adopting" a needy family and collecting toys for underprivileged children.

At our meetings, an educational film may be shown. Or we



"Who brought *me*?"

may have a guest speaker (a faculty member of a nursing school, for example).

The trips to our local hospital help the girls get an impression of what being a nurse is like. To prepare them for this experience, I teach them how to take temperatures and how to make beds. I also explain some of the ethics of nursing.

At the hospital, they do the temps and beds under the supervision of floor nurses. They also carry trays, feed patients, care for flowers, help bathe and change babies. And what a thrill they get, working side by side with the graduate nurses!

Never a Dull Moment

The club has had some exciting experiences. Take, for example, the visit we had from two Air Force nurses. They were flown in from Spokane, Wash., by helicopter. The 'copter circled over the school several times, then landed a short distance away from where we were watching. Believe me, the whole town knew about our club that day!

The high spot of the year is, I think, our Candlelight Service in March. At this service, the future nurse receives her pin—a token of merit awarded by the women's auxiliary. Mothers and

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friends are invited; and there are short talks and the solemn recitation of our club pledge.

Working with these youngsters is a real tonic. True, there are times when the giggling and chatter make me wonder whether it's worth the effort—not to mention the loss of leisure time. But if I stretched out on the couch with a good book, how many people would I be helping then? There's a hard-to-beat satisfaction in helping a teen-ager choose her lifetime career.

There's still further satisfaction in helping our profession to get more and better qualified nurses. "We have no better recruitment source than the Future Nurses Club," says the administrator of our local hospital. And that's true nationally, too.

The N.L.N. estimates that 50 per cent of future nurses club members enter schools of nursing in either the professional or the practical category, while another 8 to 10 per cent study to be lab technicians, physical therapists, etc. So it seems that future nurses clubs are here to stay.

If you want to keep young, if you'd like to add zest to your professional career, look into this really wonderful opportunity! END

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They Take the Terror Out of Child Anesthesia

Nightmare-proof anesthesia has been achieved at this hospital. And the nurse's role is crucial, says the chief anesthesiologist

By Evelyn Pastore, R.N.

THIS FEARFUL CHILD *faces a serious operation. But a skilled nurse-doctor team will allay his apprehension so he'll be ready to cooperate.*

The nurse appeared calm and collected. Watching her, you'd never guess that her patient—a 10-year-old boy—was being admitted for brain surgery. She and he talked about boat models, skin diving, Zorro, and what it's like on the moon.

But at Stamford (Conn.) Hospital, such talk isn't idle chatter. As a matter of fact, this Stamford nurse was bending every effort to win the boy's confidence. Reason: Her hospital's new program for child anesthesia is based in part on the belief that earning the patient's trust is vital.

"Most of that sense of trust has to be established by the nurses," says Dr. Frank D'An-

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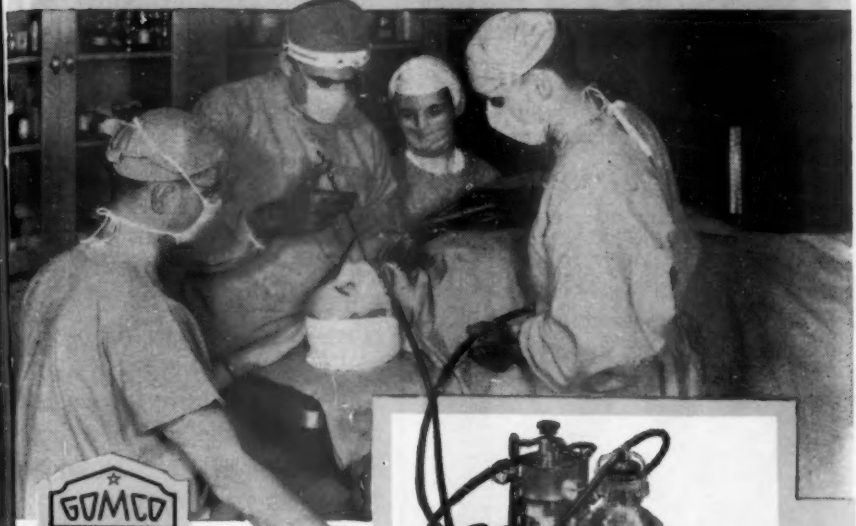

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drea, the hospital's chief anesthesiologist. "For they are the ones who spend the most time with the child."

Many adults recall the fright of a childhood trip to the O.R., with its dazzling lights, fearsome equipment, and eerie figures in white gowns and masks. Worst thing of all such memories is the ether—the struggle to escape it and then the blackout.

"Today, we strive constantly to improve our anesthetic techniques," says Dr. D'Andrea. "But most important is our attention to the special psychological needs of the child patient. Here is where nurses can do so much to help."

Parents Complicate It

Stamford Hospital has restricted parents' visiting hours, and Dr. D'Andrea explains why: He says the typical mother and father, while well-intentioned, feel—and show—their concern and anxiety. Their youngster spots this at once and becomes concerned and anxious himself. The parents' presence thus makes the child's care harder, rather than easier.

A seminar on "How to Bring Your Child to the Hospital" has shown many Stamford parents the reasons for hospital rules

This seminar—conducted for the public by three members of the Stamford Hospital staff (an anesthesiologist, a surgeon, and a psychiatrist)—stresses the more important dos and don'ts to observe whenever a youngster is hospitalized.

One of the don'ts is: Don't ever try to fool a child.

"A youngster who's been told that he's 'going to a party' and then winds up in a hospital bed, can trust no one," observes Dr. Angelo Mastrangelo, another of this hospital's anesthesiologists. "Such a child is hard to deal with and not so good a surgical risk," he adds.

As a successful example of how a youngster can be psychologically prepared for anesthesia, Dr. Mastrangelo cites the case of 4-year-old Michael:

The boy's mother attended the Stamford Hospital seminar just before her son's admission for a T. & A. So she knew how to condition him for what lay ahead.

The nurses who took over after Michael was signed in were likewise well-oriented. By the time Dr. Mastrangelo came on the scene, therefore, the boy was in good spirits.

The anesthesiologist's first step was to order a one-shot dose

of Phenergan, Demerol, and scopolamine, to be given an hour and a quarter before surgery. (This is his usual pre-op medication for a normal child; he reserves Pentothal Sodium, given rectally, for children who seem more difficult to manage.)

After the floor nurses had given him his shot, Michael, of course, became sleepy. He hardly opened his eyes, in fact, when they put him on a stretcher and pushed him to the O.R.

They Chat About Toys

"In some instances," says Dr. Mastrangelo, "we have to reassure the child by talking to him about his toys or pets. But this wasn't necessary in Michael's case. And, since he liked to sleep on his side, we permitted him to lie that way on the O.R. table."

One of the O.R. nurses took Michael's hands in hers—not as a restraint but as a measure of reassurance. (Restraint is used only when absolutely necessary.)

At the same time, Dr. Mastrangelo set the dials of his anesthesia machine for a mixture of nitrous oxide, oxygen, and cyclopropane. Then he edged the anesthesia mask slowly toward Michael's face. (The lad had no recollection of these goings-on, his mother reported later.)

When Michael was sound asleep, he was turned onto his back. Dr. Mastrangelo then inserted an endotracheal tube—a routine T. & A. procedure at Stamford Hospital. (Sometimes I.V. or I.M. succinylcholine is given for better muscle relaxation.) Then the anesthesiologist switched to gas, oxygen, and ether.

The Stamford staff finds that this two-stage method of anesthetizing has several advantages,

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namely: well-controlled depth, no anoxia, quick recovery, better exposure in T. & A.s, and no laryngospasm.

Before Michael left the O.R., he was beginning to stir a bit and whimper. Dr. Mastrangelo spoke comfortingly to him, and so did one of the nurses.

"Sometimes we even sing to a child," says the M.D. "You may think that silly, but you'd be surprised how well it works."

Michael was then taken to the recovery room, where a stack of clean gowns is always on hand for child patients. Lois Budd, the charge nurse there, says, "Blood frightens children, so we change their gowns the minute they are stained." She adds that children who are awake are screened off because "the sight and sound of a reviving anesthesia patient" can be upsetting.

When Dr. Mastrangelo went in to check on Michael, the boy was awake, but drowsy. His cough reflex was re-established, so there could be no silent bleeding. His pulse and color were good. (Nurses check these vital signs every few minutes.)

As soon as he was completely awake, Michael was returned to the pediatrics unit. Only if he'd had some bleeding would he have been kept longer in the recovery room.

Back on the ward, Michael was made comfortable, watched carefully, and again reassured that the nurses and doctors were there to help him.

His complete recovery shows that child anesthesia can be safe, quick, and nightmare-proof. Its main requirement, of course, is cooperation. And at Stamford Hospital everyone—surgeons, anesthesiologists, and nurses—works toward that goal. END

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Leprosy—Fable and Fact

Continued from 67

lepromatous type of the disease. Individuals with the tuberculoid or "closed" type are noninfectious. They can and do return to their home communities to lead useful, normal lives.

Who gets leprosy? Persons exposed to the "open" type of the disease, especially the leprosy patient's blood relatives living under the same roof.

What happens in untreated cases? The victim may suffer facial disfigurement and nodules may develop over the trunk (especially the buttocks), face, arms, and legs. He may become blind.

How serious a medical problem is leprosy in the U.S.? Not nearly so serious as heart disease or cancer. But the country has some 1,500 known cases; and stern laws in some states (as well as social stigma) are believed responsible for many other unknown cases in hiding. The disease is endemic in California, Texas, Louisiana, and Florida.

What are the chances of eradicating leprosy? Says Dr. Joseph Proctor, a Boston leprologist: "With more education and drug control, there probably will not be any leprosy (at least in the civilized world) within two generations." Says Dr. James A. Doull, medical director of the American Leprosy Foundation: "An encouraging feature of the problem is that the host-parasite relationship is delicately balanced. It is therefore possible that . . . the scales will tip in favor of man."

You can help that possibility become a reality by joining the fight against this much misunderstood disease. END

An *RN* Refresher: The Stryker Frame

Continued from 72

patient's arms by his sides and secures them with a strap if he's weak or paralyzed. If he can use his arms, she tells him to hug the anterior frame when it's placed above him.

¶ She gently lowers the anterior frame over the patient, slipping the hole at each end of the frame over the bolt on the pivoting device. (The frame's face support must be exactly flush with the patient's face.)

¶ She wraps several straps securely around the two frames between which he is now sandwiched.

¶ She screws the lock nut securely over the bolt on each pivoting device. (This is especially important, for the patient's entire weight will rest on these two lock nuts when the frame is reversed.

¶ She pulls out the spring lock at the head end of the frame. (A lever holds it out while she goes to the foot end to pull out the spring lock there.)

¶ She grasps the foot (or head)

end of the anterior (top) frame, and turns it with *one, smooth, fairly rapid motion*. The spring locks snap into place to hold the anterior frame in its new (bottom) position.

¶ The nurse then removes the posterior frame (it's now the top one) and proceeds with her care of the patient (who at this point is face down).

To return her patient to the supine position, she repeats the same steps.

Skillful operation of the Stryker frame takes a little time and practice. And one of your most important contributions when using it is the psychological support you give the patient.

Nurses who've had experience with the frame find that the average patient needs a few weeks to get used to it. He also needs time to adjust to lying either face down or flat on his back. (Aged, excitable, disturbed, or obese patients are not good candidates for the frame.)

Don't Surprise Them!

Arline Gleason, head nurse on the neurosurgical floor at New York's Neurological Institute,

advises you to explain everything carefully to the patient on the frame before you do it. The turning procedure, she says, can be especially trying to him if he doesn't know what's happening. And a minor mishap can shatter his confidence completely.

"A Stryker frame patient needs a lot more reassurance and T.L.C. than a bed patient," she says. "You can count on his making you conscious of all the little things you should do for him."

The Stryker frame is a boon to patients immobilized by spinal cord injuries, fractures of the lumbar or dorsal spine, or spinal fusion. It's no less a boon to disabled persons who are chronically ill. The device is even being used now in the open-method treatment of patients with severe burns.

A Boon to Nurses

Few R.N.s who've overcome their timidity about using a Stryker frame and have seen how it simplifies their nursing care of incapacitated patients would want to be without it if they had a choice. END

Continued from 30

point where it divides into the two common iliac arteries, the transfusion begins.

Colonel Riva says such intra-aortic transfusion is simple, safe, and often lifesaving. Blood immediately reaches the coronary and cerebral vessels. And blood pressure and circulation to the heart and brain are maintained even during severe hemorrhage or excessively traumatic surgery.

Calls Plastic-Foam Cast Superior to Plaster

Casts made of a quick-setting plastic foam are reported to be superior in several ways to those made of plaster of paris. Use of the plastic foam involves a new cast-making technique called "predesigning":

The pattern of the cast wanted is traced on a plastic "envelope." (Envelopes come in several sizes: One size is about the right length for a neck, another for an arm, etc.)

The envelope is filled with plastic foam and smoothed out with a roller. In a few minutes, shears are used to cut along the lines of the pattern. The result: a predesigned cast that can be molded to the patient's body and held in place by a bandage until completely hardened.

Dr. J. Norrie Swanson of the Arthritis Clinic at Toronto General Hospital reported his experience with the plastic foam (called Dura-Foam) to the Canadian Rheumatism Association. He stated that Dura-Foam eliminates the traditional "plaster cast mess" and won't "damage, destroy, or dirty either clothing or skin."

The plastic-foam cast, Dr. Swanson said, is light and comfortable, giving orthopedic and fracture patients greater freedom of movement. It's also waterproof and washable, he pointed out, enabling R.N.s to eliminate stains and odors due to incontinence. Perhaps most important, he added, it cuts down X-ray exposure time.

Dr. Swanson said the plastic-foam cast can be reshaped when necessary by heating it with an infra-red lamp or a special heating pad and remolding it as desired.

Charge Nurse Personally Cleanses Infant Cords

The charge nurse of the newborn nursery at Brooke Army Hospital in Fort Sam Houston, Tex., is held personally responsible for cleansing the cord and cord-cutaneous junction of each infant. She herself must do this with 70 per cent alcohol at least once during her eight-hour tour of duty.

Why?

Studies at Brooke indicate that

the umbilical stump contributes greatly to the spread of pyoderma in nurseries for the newborn. More *Staphylococcus aureus* and other potential pathogens are found on the umbilical stump than anywhere else on infants' skin.

Colonization of these organisms on and around the umbilical stump, the researchers say, can contaminate not only the air in the nursery but also the personnel handling the babies and the babies themselves.

Hints for Eliminating Trichomoniasis

To hasten the cure of trichomonas vaginitis and to help prevent reinfection, Dr. Jane Hodgson of St. Paul, Minn., says, follow these two rules:

1. Don't wear tight clothing, such as panty girdles, blue jeans, pajamas, and slacks.

2. Do take a daily tub bath (not a shower) with a detergent, and continue this right through the menstrual cycle. Douching is neither advisable nor necessary, points out Dr. Hodgson.

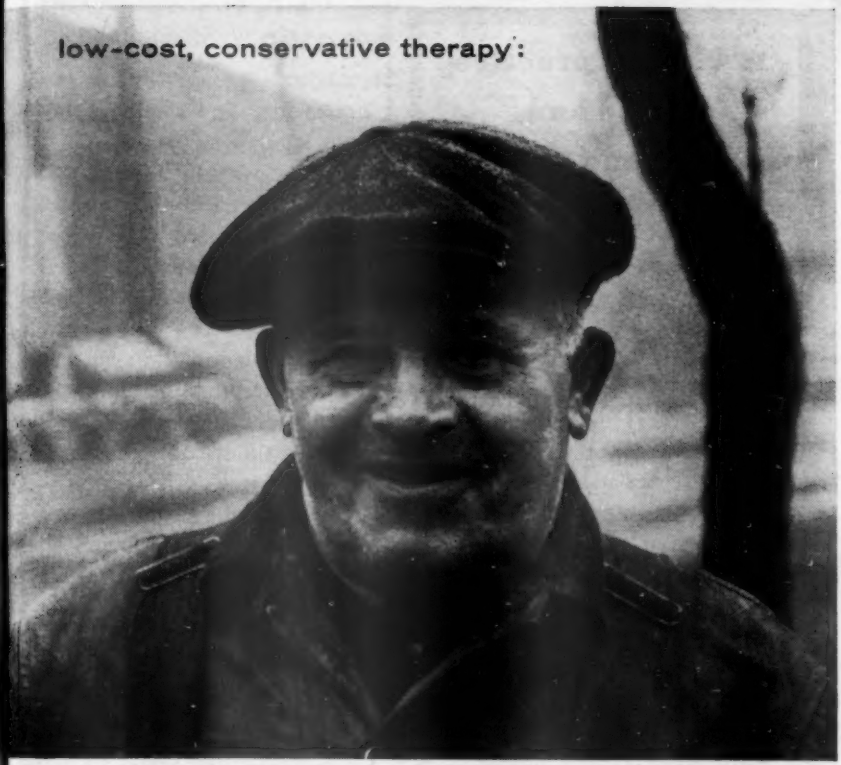
Her suggestions are part of a report to the American Medical Women's Association.

Polyethylene I.V. Catheter May Be Risky

R.N.s see danger signals in current reports about polyethylene I.V. catheters. There have been two instances recently in which a polyethylene catheter became disconnected from the I.V. tubing, slipped into the vein, and eventually lodged in the patient's heart.

One patient died and the catheter was found at her post-mortem. The other patient, a 10-year-old girl, lived after a catheter was removed surgically from her right atrium.

Discussing these two cases in the Canadian Medical Journal, Drs. G. A. Trusler and W. T. Mustard of Toronto's Hospital for Sick Children emphasize the need for looping the I.V. tubing on the pa-



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Thos. Leeming & Co Inc. N.Y. 17

1. Brusch, C.A., *et al.*: Md. State Med. J. 5:36, 1956.

news

tient's arm and securing the loop with tape or a suture.

Danger of infection when polyethylene is used for continuous I.V.s is discussed by Drs. R. W. Phillips and John D. Eyre Jr. in the New England Journal of Medicine. After a few days, they say a polyethylene catheter no longer fits the skin puncture snugly. When the patient moves his arm, the catheter slides back and forth and opens the way for infection.

As a safeguard, the doctors suggest treating the insertion site as if it were an open surgical wound. If possible, they say, every few days the catheter should be shifted to a new site.

Oral Antidiabetics might get their insulin-like effect by inhibiting the output of glucose by the liver, says a report in the British medical journal Lancet.

Labor Pains Controlled By Decompression

Labor rooms may soon be equipped with decompression devices if a new technique developed in South Africa catches on.

Mothers in the first stage of labor at Witwatersrand University Hospital in Johannesburg wear a nylon decompression suit that reportedly reduces atmospheric pressure on the abdomen. This lets the abdomen enlarge and relieves muscular pressure on nerve endings. Decompression is also said to short

in the season of

acute infections, extra

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provides the increased

VITAMIN C

and fluid needed during

FEVER

to prevent deficiency and

help maintain resistance*

*Tisdall and Jolliffe note the systemic relation in animals between vitamin C and resistance to infection, with increased needs evident in upper respiratory streptococcal infections.

— In: Clinical Nutrition ed. by Norman Jolliffe et al. New York, Paul B. Hoeber, Inc., 1950, pp. 590-91, 637-38.

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en labor by reducing the number of contractions needed.

The suit is equipped with a valve control that's operated by the patient. Best results are said to be obtained by reduction in pressure of one pound per square inch below the atmospheric level.

Hypnosis Sanctioned For Medical Use

"The use of hypnosis has a recognized place . . . in the treatment of certain illnesses when employed by qualified medical and dental personnel," says the American Medical Association. But the society:

¶ Urges practitioners "to be aware of the complex nature of the phenomena involved."

¶ Disapproves of teaching limited to induction techniques alone.

¶ Warns that these techniques require so little skill and training that their use is "meat for the charlatan."

¶ Recommends "high-level research" into aspects of hypnosis that are still unknown and controversial.

¶ "Vigorously condemns" the use of the art for entertainment.

The A.M.A. is "in essential agreement," it says, with a comprehensive report on hypnotism published in 1955 by the British Medi-

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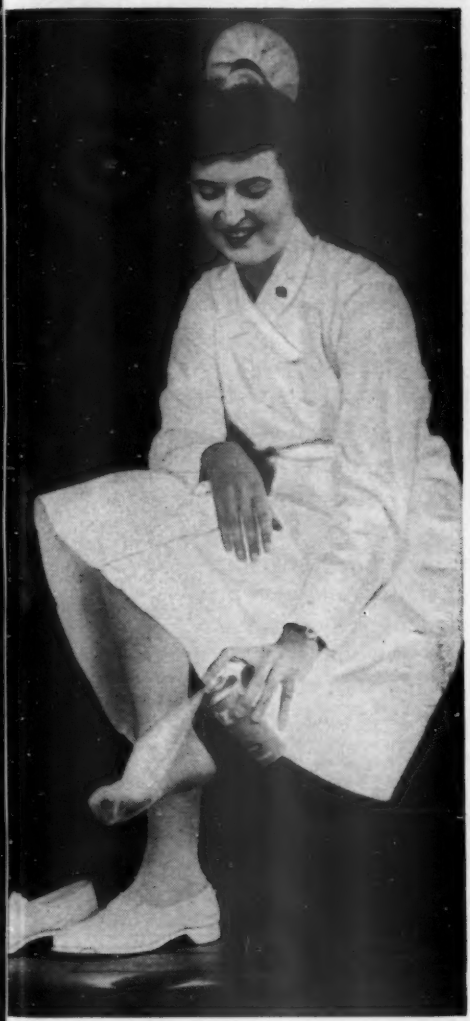

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Nobody ever died of brittle fingernails. That's not to say that this all too common feminine problem has not caused much patient distress and even some professional perplexity.

Happily a new prognosis is possible for better than seven out of ten women with brittle fingernails. One to three envelopes of Knox Gelatine a day for three months restore strength in approximately 80% of patients.[1,2,3,4] Improvement is usually apparent in 30 days.

Adequate intake of Knox Gelatine (min. 1 envelope —7 Gm. or 120 grains per day) is absolutely essential to produce the Specific Dynamic Action necessary to correct the brittle nail defect. If you would like to examine at first hand the clinical research establishing this use of Knox Gelatine, just use the coupon below.

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Professional Service Department, Johnstown, N. Y.
please send reprints of the following articles:

- ☐ 1. Rosenberg, S., Oster, K.A.: Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

YOUR NAME AND ADDRESS

before Knox after K

cal Association. Among other things, the B.M.A. report said in effect:

¶ Most people can be hypnotized, but only a minority will go into a deep trance in a single session.

¶ Like other remedies, hypnotism has its indications and contraindications, and it should not be regarded as a specialty independent of psychological medicine.

¶ There's a place for hypnotism in the treatment of psychiatric disabilities, in the production of anesthesia and analgesia for surgical and dental operations, and—among suitable subjects—for the relief of pain in childbirth.

¶Use of hypnotism without expert knowledge provides no control if powerful emotions are released. Its use, therefore, should be confined to those who subscribe to the ethical code governing the doctor-patient relationship. (But this need not preclude a suitably trained "medical auxiliary" working under the direction of a physician.)

¶Instruction in the clinical use of hypnotism should be given to all trainee specialists in psychological medicine, and possibly to trainee anesthetists and obstetricians.

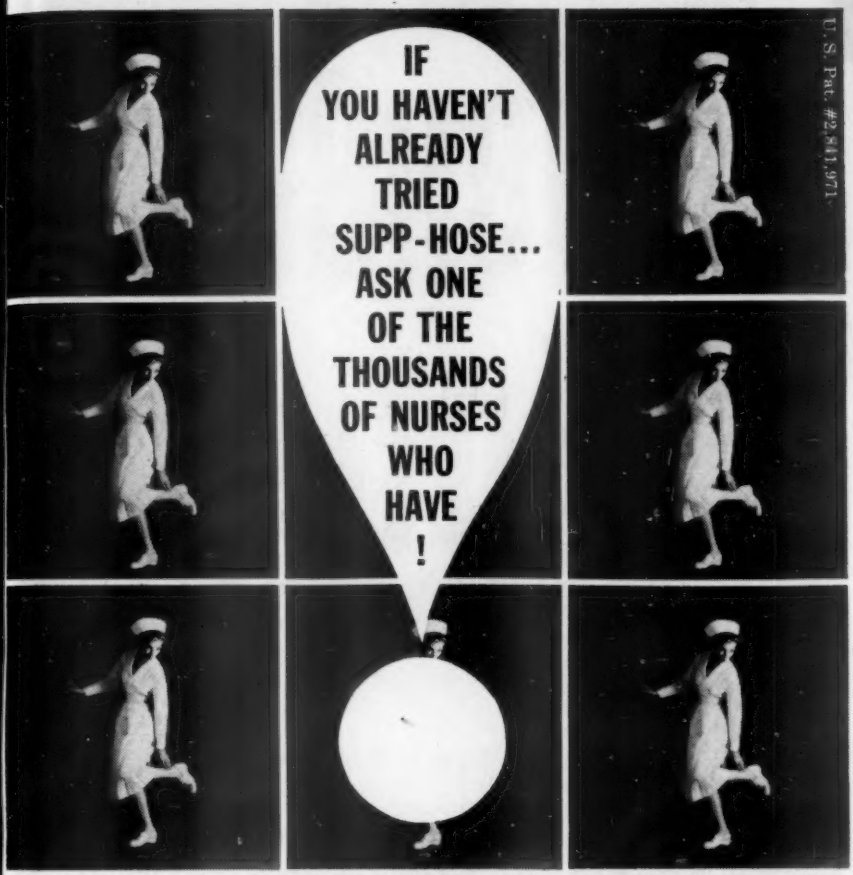
¶Under no circumstances should female patients be hypnotized except in the presence of a relative or a person of their own sex.

Too Much Education? Nonsense, Says M.D.

"A lot of nonsense has been written and spoken about giving nurses too much education and 'pulling them away from the bedside.' . . . It is my firm conviction that with the right kind of leadership in nursing service administration much of the shortage in mere numbers can be overcome. This kind of leadership, however, requires more and better education, not less . . ."

So says Dr. Dean A. Clark, director of Massachusetts General Hospital.

From the qualitative standpoint, Dr. Clark backs up his contention with the reminder that "true edu-



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Fashionably sheer Supp-hose lifts and soothes tired leg muscles, gives gentle support all day long. Yet Supp-hose contains no rubber! Here is the wonderful support stocking ideally suited for your leg-wearying daily routine.

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One pair of Supp-hose should give you many times the wear of ordinary nylons. It's easy to care for . . . looks and washes like any other fashion stocking. Try a pair—see how good your legs look, and feel! Available in proportioned hosiery sizes in white and fashion shades. **4.95** pair

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premenstrual te

'DIURIL'
(CHLOROTHIAZIDE)

FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

". . . in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

DOSAGE: one 500 mg. tablet 'DIURIL' daily—beginning the first morning of symptoms and continuing until after onset of menses. For optimal therapy, dosage schedule should be adjusted to meet the needs of the individual patient.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

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Distress
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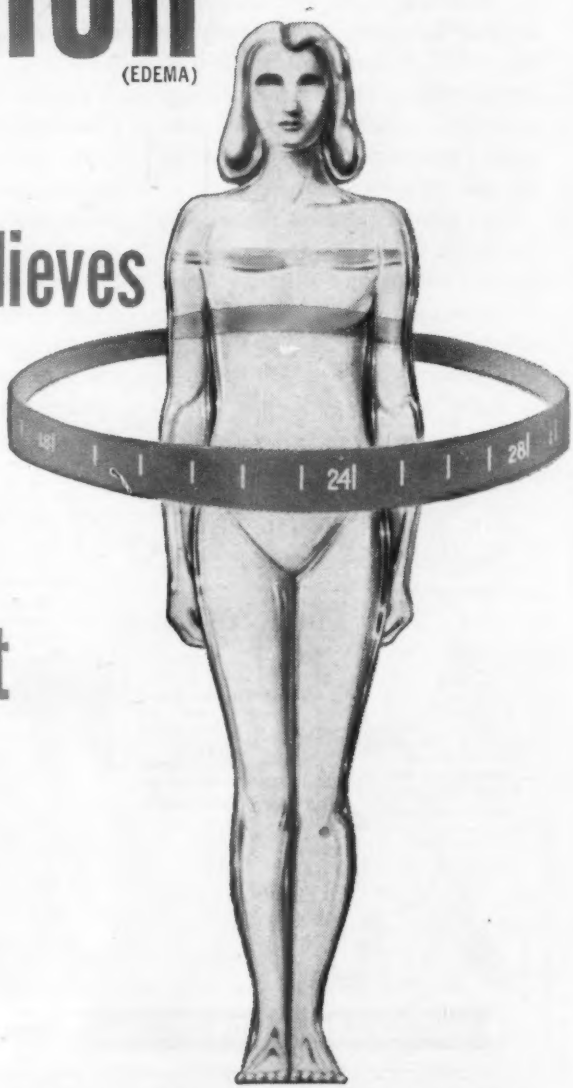

ANY INDICATION FOR DIURESIS IS AN INDICATION FOR 'DIURIL'

cation is never a waste." It's the quantitative angle that concerns him.

As matters now stand, he says, the nation's 7,000 hospitals must depend for their R.N. supply on less than 1,100 schools of nursing. Result: Some hospital schools operate at a deficit—a loss the hospitals must meet by boosting charges to patients.

Dr. Clark believes some way should be found for the support of nursing education by the 5,900-or-so nonteaching hospitals who use nurses graduated by institutions with schools.

"I also say," he adds, "that every hospital, large and small, rural or urban, can be a teaching institution. By this I mean it can participate in the education of its medical staff, its graduate nurses, technicians, and the community."

Frequency of Smear Test Challenged by Study

Early cancer detection in women has been said to require a cervical smear test at least once a year and possibly every six months. But a Milwaukee Hospital research team suggests, in a report to the American Medical Association, that once every two years may be enough.

The investigators studied a sam-

ple of 15,389 women. Their conclusion: If no sign of malignancy is revealed by a thorough physical examination (including a smear test), there's little probability of cervical cancer for at least two years.

Oral Vaccine for Polio Called Effective

Mass immunization of some 245,000 African natives with live-virus polio vaccine, given orally, shows it to be safe and effective, a research team reports in the British Medical Journal.

The team, headed by Drs. Hilary Koprowski of Philadelphia's Wistar Institute and Ghislain Courtois, a Belgian Congo health official, says no sickness followed the mass immunization and no new cases of paralysis were reported in four areas previously hit by polio epidemics.

This field trial, one of several that are under way (or being planned) in various parts of the world, is said to be the first full-scale test on which results have been reported.

Capsules

Child's query, "Why do men have nipples?" has Cleveland Academy of Medicine stumped . . . *More*▶

. . . Postpartum foot-drop due to sacral nerve injury can become permanent if not treated in time, Toronto's Dr. W. G. Whittaker warns. He urges R.N.s to watch for early signs of foot-drop—e.g., numbness, weakness, tingling, pain in legs . . . Watch for publicity barrage from A.M.A., aimed at food faddism and false advertising. Association will whack at such terms as "tired blood," "nature's remedy," "brain foods," "secret cure." . . . Deaths from measles (410) topped those from polio (220) in 1957 . . .

Bees and hornets caused 82 U.S. deaths, snakes only 71, a recent five-year study shows . . . Student nurses' bazaar at Syracuse (N. Y.) General Hospital featured discarded I.V. sets for watering house plants automatically. "Adjust drip. Keep soil moist when you're away," patrons were told. Result: I.V. sets outsold baked goods, candies, needlecraft items . . . Medicine reportedly losing as many M.D.s through drug addiction each year as it gains through graduation of a large medical school class . . .

Cancer cells are often removed from blood stream by shock of surgery, says report from University of Illinois Medical School . . . Penicillin "fall-out"—airborne particles of the drug—may be helping to develop resistant staph strains, Texas U.'s Dr. Jay Sanford believes . . . There's now a National Society of Friends of the Mentally Ill, Inc. President: Nurse Marie Oswald of Sunnyvale, Calif. . .

National Cancer Institute making house-to-house, farm-to-farm study in Washington County, Md., of all possible factors in cancer incidence—e.g., geology, geography, genetics, nutrition, radiation, agriculture, weather . . . Greece's 20-year-old Princess Sophia is now head nurse on ward at Mitera Infant Center, Athens . . . Tetanus antitoxin injection may temporarily paralyze vocal cords, reports Milos Basek, M.D., in Laryngoscope . . . Children cooperate better during eye exams with a large mirror nearby in which they can watch what's happening, Children's Service Center, Wilkes-Barre, Pa., has found. . .

Merthiolate currently available in plastic, push-button, spray bottles . . . Catholic Hospital Association now publishing one-volume "refresher course" called "Understanding Medical Terminology" . . . Sedative overdose accidentally given by nurse caused death of patient, a Chicago coroner's jury has ruled. Hospital is being sued for $30,000 . . . Injectable, sterile distilled water can now be produced directly from boiler steam with unit available from Wilmot Castle Co. . .

San Francisco hospitals said to

new 3-way build up for the under par child...

Improve appetite and energy
with ample amounts of vitamins — B_1, B_6, B_{12}.

strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia
with iron in the well-tolerated form of ferric pyrophosphate... plus sorbitol for enhanced absorption of both iron and B_{12}.

new

INCREMIN*

Lysine-Vitamins

WITH IRON SYRUP

delicious cherry flavor— no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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news

be finding commercial baby formulas safer, less expensive than those prepared by own personnel . . . Aerosinusitis—acute or chronic inflammation of sinuses—can strike airplane occupants if their sinuses are blocked by mucus plugs during take-off and landing, says report from Maxwell Air Force Base . . . American Association of Blood Banks setting up nation-wide index of rare-type-blood donors. Headquarters: Blood Center, Milwaukee . . .

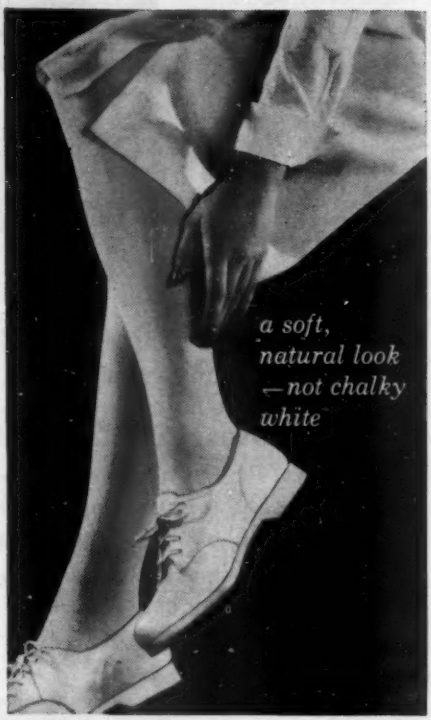
Rheumatoid arthritis and some related diseases may affect the mind, Academy of Psychosomatic Medicine reports . . . Esophageal obstruction in a 5-year-old girl was reported to have been caused recently by a urine-sugar reagent's lye content . . . For women only: Six-day treatment for alcoholism offered at moderate cost by Totairn, Inc., new 12-bed nonprofit center in Indianapolis . . .

A new cardiac defibrillator is said to be effective through the unopened chest. Either doctor or nurse can use it. Already, it has saved a number of lives . . . Newborn's blood oxygen is increased when mother uses oxygen mask during delivery. This can be life-saving in prolapse of cord or abruptio placentae, says University of Illinois' Dr. J. H. McClure . . . Tetanus protection can be made continuous with a booster dose of tetanus toxoid every five years, says Physician's Bulletin. END

Don't settle for part-elastic support hosiery

get full support all day

White All-Elastic Stockings by Bauer & Black stay "on duty" as long as you do



As a nurse, you need the kind of leg support that works full time—to make staying on your feet easier. You can't get this with "stretch nylon" support hosiery (the kind that stretches but doesn't spring back), nor with part-elastic hose. What you need is *all*-elastic stockings by Bauer & Black—with rubber in every supporting thread.

Bauer & Black Stockings are white, but not chalky white. They have that soft, natural look. And the full-footed styling makes them as fine and fashionable as your regular nylons. They stay white, dry quickly. Non-binding heel and toe. Try a pair. You'll see why many nurses buy several at a time.

***Also available**—elastic stockings like the above in natural street shades. Other models in nylon or cotton, above or below knee style, open or closed toe, at a variety of prices. Black for ecclesiastical wear.*

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MAIL COUPON FOR COMPLETE INFORMATION

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Send me a copy of your free booklet on the care of varicose veins with Bauer & Black Elastic Stockings, for new leg beauty and comfort.

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Facts every nurse should know to...

CONTROL INDIGESTION NAUSEA DIARRHEA

Indicated: Pepto-Bismol for prompt, lasting control of distress throughout the G. I. tra

For gastritis: Pepto-Bismol's bland, non-alkalizing demulcent base hel return stomach to normal activity—without inhibiting digestive enzym and without risking side effects of alkalosis or "acid rebound."

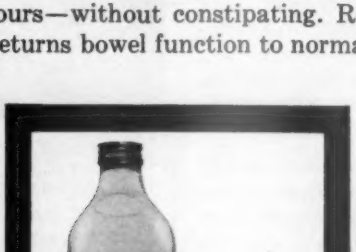
For enteritis: Pepto-Bismol effectively protects intestinal mucosa with i completely soothing, coating action. Pepto-Bismol offers prompt, sa relief for both physical and psychogenic disturbances.

For diarrhea: Pepto-Bismol's non-opiate formulation controls commo diarrhea within 24 hours—without constipating. Relieves gas pains an abdominal cramps—returns bowel function to normal.

Safe and effective for children and adults.

Contains no sugar.

Active ingredients: Bismuth Subsalicylate, Salol and Zinc Phenolsulphonate in a demulcent base. Note: Pepto-Bismol's bismuth salts may cause temporary darkening of the stool.



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MINISTRATORS: (a) Nurse for brand hsp 35 beds, facilities increase to 50, all friendly community near leading metro. top salary, M.W. (b) Small hsp on adian border, exc. living accom, $6000 2-1 Burneice Larson, Medical Bureau, 900 Mich gan Ave., Chicago, Ill.

ESTHESIA COURSE: The Memorial Hos- al, Danville, Va., offers an 18 mos course Anesthesia for registered nurses. All nts and techniques taught. Complete main- ance and st.pend pd for entire course. proved by the AANA and G.I. approval. sses accepted in April and October. For rmation write Miss Virginia L. DeMaio, NA. Director School of Anesthesia, The morial Hospital, Danville, Va.

ESTHETIST-NURSE: Immediate open- for Nurse Anesthetist, 4 on staff, one esthesiologist, air-conditioned, new dept, d salary, Social Security, vacation sick lv, idays, meals, laundry. Call or write Robert Murphy, Administrator, Floyd Hospital, me, Ga.

ESTHETISTS: (a) Only one on staff 60 hsp, prosperous Iowa farm community, rage $700. (b) OB, leading N.Y.C. hsp, living, working conditions, to $6000. (c) o, general hsp on Mexican Border, $6600. Male, new 50 bed hsp, excellent financial port. Illinois. RN2-2 Burneice Larson, Medi- Bureau, 900 N. Michigan Ave., Chicago,

SISTANT DIRECTOR OF NURSING RVICE: JCAH, 250 bed general hospital, or M.S. degree and at least six years ex- ience in supervision, teaching or assistant eting required. Good personnel policies, ry depending upon preparation and ex- ence. Pittsburgh is 40 miles from the hos- l. Apply Director of Nursing, Ohio Valley spital, Steubenville, O.

SISTANT DIRECTOR OF NURSING RVICE: Immediate opening. Supervisory erience required. 300 bed general hospital. ool of Practical Nursing. Excellent person- policies. Write Director of Nursing, rkoff Heights Hospital, 374 Stockholm St., ooklyn 37, N. Y.

ST DIRECTOR NURSING SERVICE: AH accredited hosp. of 242 beds in Chicago urb. Degree and supervisory experience d. Salary dependent upon experience and lifications. Liberal personnel policies. Ap- Director Nursing Service, Ingalls Memo- Hospital, Harvey, Ill.

TENTION GENERAL DUTY & SUR- RY NURSES: 400 bed County Hospital lo- d 2 hrs drive from San Francisco, ocean ches and mountain resorts in modern and gressive city of 35,000. 40 hr 5 day wk, 3 pd vacation, 11 pd holidays, pd sick lv, rement plan and Social Security. Accom- dations in nurses' home, meals at reason- e rates, uniforms laundered without charge. Duty $333 mo start plus shift and serv- ice differentials. Surgery $382 to $460 mo comp. time if on call. Must be eligible for Calif. registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, Calif.

BETTY HARTWIG says there are vacancies at the Hospital here in L.A. If you're thinking of moving, write her c/o L.A. County General Hospital, Box 1311, Los Angeles 33, Calif.

CALIFORNIA might not be heaven, but it's the next best thing—and that's our honest opinion. If you're planning a move— move here and see for yourself. With 6 mos. exp. you will be pa.d $395 mo. Please write me. Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, Los Angeles 33, Calif.

CAMP NURSES: R.N.'s (2) and doctor for Connecticut co-ed camp. Excellent conditions and salary. Camp Birchwood, 67-38 108th St., Forest Hills, N.Y.

CHARGE NURSES at L.A. County General Hospital receive $412 per mo for eve and night shifts. Please write me for full information re job opportunities here. Betty Hartwig, R.N., Box 1311, L.A. County General Hospital Los Angeles 33., Calif.

CLINICAL INSTRUCTOR: 1 for pediatrics, 1 for psychiatrics and one for obstetrics. Newly opened school of professional nursing. Salary beginning at rate of $5340 for B.S. Degree or $6420 for Masters Degree. Excellent personnel policies. For complete details write to: Miners Memorial Hospital Association, Box 61, Williamson, W. Va.

DIRECTOR-NURSING SERVICE: 75 bed gen hosp, fully accred., expansion prog., liberal salary range and employee benefits. Midwest, pop. 10,000. Rail and bus connections excellent to larger cities. Contact Administrator, Lawrence County Memorial Hospital, Lawrenceville, Ill.

DIRECTOR OF NURSING—CALIFORNIA: In lge gen hosp. with nationally accredited school of nursing July '59. A challenging position in modern teaching hosp. Masters Degree with preparation and/or exp. in administration req'd. Starting salary $577, maximum $701. Good personnel policies. For information write Personnel Director, 732 E. Main St., Stockton, Calif.

DIRECTORS OF NURSES: (a) Foreign assignment, supervise central nursing office American owned overseas operation, $10,000, paid air travel. (b) Direct Nursing Service, 60 bed hsp on the ocean, Fla., top salary. (c) Direct nursing school and service, 250 bed hsp, 100 students, beautiful eastern seaport, near Cape Cod, $7500 up. (d) Direct psychiatric Nursing service, large mental hsp, M.W., $12,000. RN2-3 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

EXPERIENCED NURSE ANESTHETIST: Phone or write Yolo General Hospital, Woodland, Calif.

GENERAL DUTY: 40 hr wk, 84 bed hospital,

finest equipment, very liberal personnel policies and pleasant working environment. Must be willing to rotate shifts. Salary range $302 to $411 monthly. Atomic Energy Project but not Civil Service. Write Director of Nursing Service, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY NURSES: Positions in a system of 10 integrated hospitals for general duty nurses qualified by professional training and personality to provide quality bedside care. Salaries at the rate of $4440 and $4860 per annum, depending on experience. Annual increases. 40 hr work wk. Shift differentials where applicable. 4 wks pd vacation, 7 pd holidays, Sick lv plus employee health program. Social Security plus noncontributory retirement plan. Also positions available for head nurses and asst. head nurses who have had administrative experience. Salaries at the rate of $5340 and $6420 per annum. For application and further details send card or letter to Miners Memorial Hospital Association, Box 61, Williamson, W. Va.

GENERAL DUTY NURSES: 118 bed general hospital located in a beautiful residential section along the North Shore of Chicago. Salary $340 days, $370 eves., $360 nights. 40 hr. wk. Modern ranch style nurses' homes with attractively furnished private bedrooms. Contact Personnel Director, Highland Park Hospital Foundation, Highland Park, Ill.

GENERAL DUTY NURSES: Immediate openings in OR, Obstetrical and Medical and Surgical Units. Rotating or permanent afternoon or night tours of duty. Bonus of $20 for OR, afternoon and night tours. New 196 bed hospital, 45 mins from NYC. Modern nurses residence. Apply Director of Nursing, Phelps Memorial Hospital, North Tarrytown, N.Y.

GENERAL DUTY NURSES: 600 bed teaching hosp in central Calif. In-service educational program, 40 hr wk, 11 holidays yrly, retirement & sick lv plan. P.M. and night shift differential. $337 per mo to start. Write Personnel Director, 732 E. Main St., Stockton, Calif.

GENERAL DUTY NURSES: 210 bed teaching hospital 35 mi from NYC. $290 per mo, 40 hr wk, $30 differential for eve duty, $20 for nights, regular increments. Liberal sick lv, vacation, 8 holidays, Social Security, laundering of uniforms, pleasant living facilities available. Director of Nursing, White Plains Hospital, White Plains, N.Y. WH 9-4500.

GENERAL DUTY NURSES: Positions available in fully accredited hospital operated by Benedictine Sisters of Elk County, St. Ma... Pa. New wing to be opened sometime... Nov. Write to: Directress of Nurses, And... Kaul Memorial Hospital, St. Mary's, Pa., ... copy of personnel policies.

GENERAL DUTY NURSES: All shifts, ... bed hospital central California. 5 day ... paid holidays, paid sick lv. and vacation p... $310 per month plus $10 for 3 to 11 P.M. ... 11 P.M. to 7 A.M., yearly increases. Superv... 3 to 11 P.M. $351 to start. O.R. Nurse, $32... start, living quarters on grounds. Write ... Director of Nurses, Madera County Hospi... Madera, Calif.

GENERAL DUTY NURSES: Wanted ... mediately to work in new, modern hosp... area consisting of new facilities, town, ... taurant, hotel and year around recreat... Excellent starting salary, pd hosp. and su... cal insurance plan and pd annual vacati... Extra shift pay and overtime. Attrac... nurses' quarters. Write William J. B... Personnel Dept., White Pine, Mich.

GENERAL DUTY NURSES: 120 bed h... southern Wyoming community of 12,000. ... eral personnel policies, 40 hr wk, starting ... ary $300 with a charge of $23 for full m... tenance, additional $10 per mo for eve ... night duty with regular increases. Surg... nurses starting salary $310 plus $5 per ... after 5 pm. Write Director of Nur... Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES & OR NURS... 3-11 p.m. gen. duty, hospital on San Franc... Bay. 5 day wk, salary $320 plus $15 added ... 3-11 and $10 for OR duty. Maintenance a... able. Director of Nursing, Alameda Hosp... Alameda, Calif.

GENERAL DUTY REGISTERED NURS... 30 bed general hospital. Write Director ... Nurses, Blue Mountain General Hospi... Prairie City, Ore.

GENERAL DUTY STAFF NURSE: New ... modernized 300 bed general hospital o... top salaries and opportunities to adva... Evenings $76.80-$89.60 per wk, nights $7... $86.10, days $64.00-$75.60. Openings ... Medical, Surgical, Obstetrics, Pediatr... Operating Rooms and Emergency Ro... 40 hr wk, merit increases, liberal poli... On Long Island Sound, 45 mins to N.Y. ... Modern nurses residence and school. Ap... Director of Nursing, Stamford Hospi... Stamford, Conn.

GENERAL DUTY, SURGICAL AND PE... ATRIC NURSES: 276 bed gen. hosp, in r... dential suburb of Chicago. 40 hr wk, c... salary and live in, $265 day duty, $285 ...

y, $280 night duty plus private room in nurses residence, 3 meals per day and laundry of uniforms. Cash salary and out, $310 day duty, $330 PM duty, $325 ht duty plus 1 meal and free laundry of forms. Low rental apartments available married nurses. Planned service increases regular intervals. Many other benefits. ite Personnel Director, MacNeal Memor- Hospital, Berwyn, Ill.

NERAL DUTY STAFF NURSES: Va- cies on all services due to completion of wing which will increase bed capacity e 400. Private general hosp. with 150 dent school of nursing, 3 yr diploma course. iversity nearby for advanced study. 40 hr Excellent salary and liberal benefit pro- m in outstanding midwestern institution. trally located in the city and convenient residential and shopping facilities. Living mmodations adjacent to hospital available ominal rent. Contact personnel director. waukee Hospital, 2200 West Kilbourn Ave., waukee 3, Wisc.

NERAL STAFF NURSES: 370 bed ap- ved gen hosp, intern and resident program. 5 per mo starting salary, $15 per mo merit reases at 12, 24, 36 mos. 40 hr wk. 2 wks vacation, pd sick lv accumulative to 30 days, d holidays. Pleasant coast city in outstand- recreational area. Apply: Director of Per- nel, Seaside Memorial Hospital, Long Beach Calif.

NERAL STAFF NURSES: For JCAH ac- dited 392 bed gen hosp with NLN accredit- School of Nursing. Will open new 5 story first of yr. Hospital ideally located in dential section of city nr NY, Phila. or shore. Liberal personnel policies including e Cross, Pension Plan, 40 hr wk, $30 mo s for 3-11:30 and $20 mo for 11-7:30. portunities for advancement. Recognition n for experience. Apply to Director of sing, Mercer Hospital, Trenton 8, N.J.

NERAL STAFF NURSES: Because we are ndly people it is fun to work in the pre- ed department of a 200 bed JCAH gen- hospital enthralled in the extensive build- program creating opportunity for ad- ement. Liberal personnel policies include r wk, retirement plan, Social Security, hospitalization insurance premiums, cu- ative 30 day sick leave, 2 wks vacation, idays, excellent meals at cost, cozy rooms 0 per mo, in-staff educational program. roximate initial salary eves $349, nights days $325. Annual increase yearly ap- imates $215. High standard patient care maintained by nurses permitted to use professional preparations. Ideally located near Detroit with convenient transportation to make off duty hrs. interesting. For details write Director of Nursing. Wyandotte General Hospital, Wyandotte, Mich.

GRADUATE NURSES: Openings in operating room and on general staff. New, modern 279 bed general hospital in Greenwich, Conn. Only 28 miles from New York City located on Long Island Sound. Recreational facilities unlimited for leisure hrs. or vacation. Annual salary $3800 to $4400 rotating shifts. Differential for permanent evenings $300 and for permanent nights $250 per annum. Premium paid for O.R. on-call time. Semi-annual rate adjustments, liberal personnel policies, 5 day, 40 hr. wk., 8 pd holidays, pd. vacations according to tenure up to 20 working days, accumulative sick lv. to 26 weeks., pd. Blue Cross and Blue Shield hospital insurance, Retirement Plan, Social Security benefits. Apply Personnel Department, Greenwich Hospital, Greenwich, Conn.

GRADUATE NURSES: For medical and surgical services, modern 263 bed mid-Manhattan hosp. 5 day 40 hr wk. Starting salary floor duty $310, Eves. $350, midnights $340, scrub nurse $320. Uniform laundry, 2 meals per tour. 4 annual increases, 4 wks vacation, 12 holidays, sick lv 12 days per year cumulative. Social Security, Health Service, free hospitalization. Opportunities for special assignments, research nursing bonuses and post-grad. study. Housing agent available. Apply Supt. of Nurses, James Ewing Hospital, 1250 First Ave., New York 21, N.Y.

GRADUATE NURSES: For general duty, 75 bed general hospital, new air-conditioned, with modern equipment. Beginning salary $275 a mo with differential for eve and night duty and operating room nursing. Good personnel poiicies, 5 day, 40 hr wk, vacation, pd sick lv, holiday time. Located in beautiful central Florida. Apply Director of Nurses, Seminole Memorial Hospital, Sanford, Fla.

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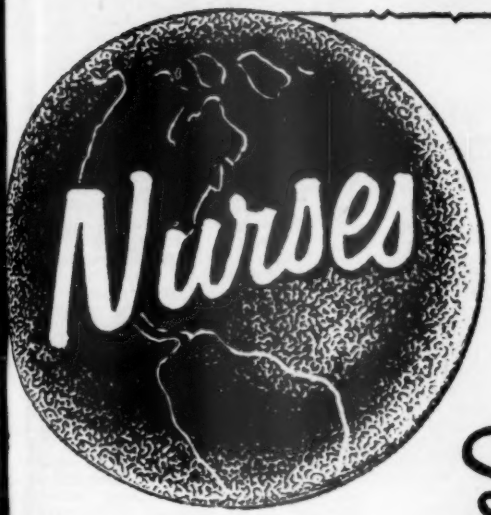

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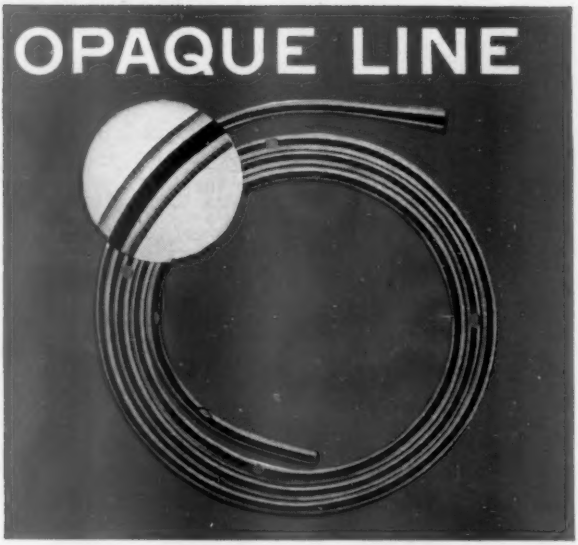

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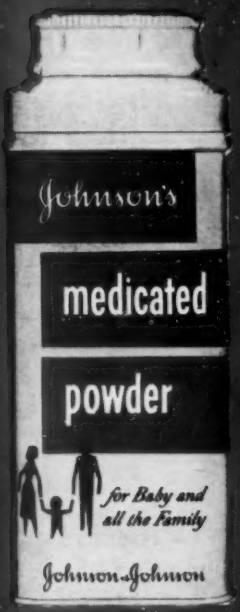

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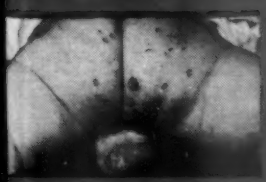

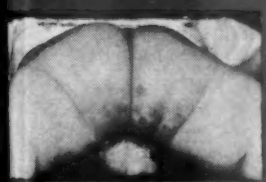

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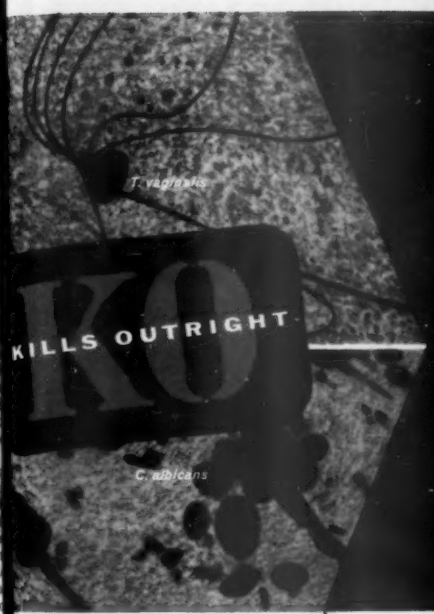

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POST T&A

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** Only one injection of "PREMARIN" INTRAVENOUS was required for rapid hemostasis in practically all cases of hemorrhage following tonsillectomy or adenoidectomy.[1,2]

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1. Menger, H. C.: J.A.M.A. 159:546 (Oct. 8) 1955.
2. Published and unpublished case reports.